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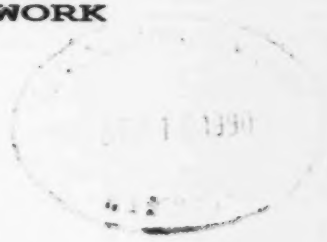
MANITOBA HEALTH

TASK FORCE ON EXTENDED TREATMENT BED REVIEW

REPORT TO

THE STEERING COMMITTEE OF THE HEALTH ADIVSORY NETWORK



APRIL, 1990

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MANITOBA HEALTH
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REPORT TO
THE STEERING COMMITTEE OF THE HEALTH ADVISORY NETWORK
APRIL, 1990

INTRODUCTION

- The Purpose and Spectrum of the Report

This Report has been prepared in response to a request from the Minister of Health for early recommendations affecting the number and location of extended treatment beds in the City of Winnipeg. The Minister's urgency relates to an earlier decision to suspend construction projects at the Winnipeg Municipal Hospital, the Concordia Hospital, and the Grace General Hospital as well as the opening for operation of 90 beds at the Deer Lodge Centre. All of the named facilities had plans relating to the use of extended treatment beds.

Since the Task Force on Extended Treatment Bed Review had a broader mandate affecting the entire Province of Manitoba and in deference to the difficulties associated with the suspension of the Winnipeg facilities' projects, this report provides information and recommendations pertinent to the distribution and use of non-acute care beds as well as their impact on acute care beds.

Although the personal care home bed needs were not included in the original terms of reference for the Task Force, it became evident early in the deliberations that no long-term bed groupings could be studied in isolation. Furthermore, the Task Force was asked to provide recommendations for changes in the policies and procedures in acute care hospitals and personal care homes that would optimize the utilization of extended treatment beds. Accordingly, the Task Force has included recommendations concerning the supply and distribution of personal care home beds in Winnipeg.

This report has not provided recommendations pertinent to palliative care programs or night care programs.

In regard to palliative care, the Task Force acknowledges that it is being provided in the community and various institutional settings. However, the Task Force believes that the associated issues are complex enough to warrant a separate study of palliative care by another Task Force. For example, there are a variety of attitudes and practices within the institutions with some hospitals preferring special units while others favour integration of the service throughout the facility. There are also community groups which hold a diverse set of beliefs; the elements of short term care, long term care, and acute care, as well as the community are involved; and, the distinction between terminal care and palliative care needs to be clarified.

With respect to night care, the Task Force interpreted it to be a program in which individuals would be transferred from their homes nightly to a community or institutional location for overnight supervision. This would allow the family or other primary care giver to rest so that they could resume their supervisory role in the day and evening in the home.

The Task Force found no explicit need for an adult night care program. It was reported that personnel of the Long Term Care Program Division of the Manitoba Health Services Commission and of Continuing Care had reviewed the concept previously and determined that there was no need for such a program.

However, it was noted that Continuing Care presently arranges for nightly supervision of individuals in their homes under appropriate circumstances.

Furthermore, there was concern about the impact on the mental health of the persons being supervised if they were to be transferred on a nightly basis to unfamiliar surroundings. Finally the practicality of the nightly transferring was also questioned by the Task Force.

- The Review Assignments

At the time it was established the Task Force was specifically requested to review:

1. the definition of extended treatment now used by the Manitoba Health Services Commission.

2. the current supply of extended treatment beds in Manitoba and future requirements based on population projections and planning parameters established by the Manitoba Health Services Commission or on such other considerations as the Task Force deems to be appropriate.

3. in light of 1 above, the proposals for development of extended treatment beds before the Commission and Government.

4. existing policies and procedures governing extended treatment bed use with a view to identifying impediments to optimum utilization.

5. existing policies and procedures governing use of personal care home beds with a view to identifying ways in which they might become accessible to patients requiring extended treatment.

6. special requirements of the young disabled and the relationship of extended treatment palliative care, adult day care, and adult night care programs or facilities.

7. relevant recommendations in the Report of the Manitoba Health Services Review Committee and the Report of the Task Force on the Young Disabled.

- The Recommendation Assignments

The Task Force was asked to make recommendations concerning:

1. desirable amendments to the definition of extended treatment.

2. the number of extended treatment beds to be provided in Manitoba by 1996.

3. the location of the extended treatment beds specified in 2 above.

4. the policies and procedures that should govern the utilization of extended treatment beds.

5. changes in policies and procedures in acute care hospitals and personal care homes that would optimize the utilization of extended treatment beds.

6. initiatives required to meet the special needs of the young disabled.

7. linkages to programs of palliative care, adult day care and adult night care.

- The Deliberations Process

Following the confirmation of its membership on April 21, 1989 the Task Force on Extended Treatment Bed Review held its first meeting on May 26, 1989 with Dr. A. Naimark, Chairman of the Health Advisory Network presenting the assignments. Since then 29 meetings (130 hours) were held as well as a preliminary submission to the Steering Committee of the Health Advisory Network in late November.

On July 25, 1989 there was a meeting with representatives from the Winnipeg hospitals, including Deer Lodge Centre, 1) to share information about the Task Force terms of reference, demographic information, proposed definitions pertinent to extended treatment, statistical information concerning bed use according to the proposed definitions; 2) to confirm the statistical information utilizing feedback from the facilities; and 3) to encourage and receive reaction and response to the material presented. The objectives were pursued through presentations, handouts, and discussion.

On September 25, 1989 a number of physicians with a specific interest and expertise in Geriatric Medicine attended a Task Force meeting to discuss the rehabilitation component of non-acute beds and to obtain their opinion regarding the establishment of a common referral and admission process for these beds in Winnipeg. This was followed by a second meeting with the group on November 1, 1989 to receive their written recommendations and comments.

A copy of a draft report, dated August 30, 1989, concerning the needs of brain injured patients by Dr. N. Hill, Section of Neurosurgery of the Faculty of Medicine, was reviewed by the Task Force. This was followed by a second document received on December 17, 1989.

The information gathering and analyses has involved the members of the Task Force and a number of government personnel in addition to the requests to individuals, agencies, and other provinces. The Minister assigned a high priority to requests from the Force and the Department responded expediently. Resource personnel assisted in facilitating the entire process associated with the deliberations.

The Task Force has catalogued over 100 items of information consisting of reports, recommendations, analyses, projections, listings, etc. which it referenced in its discussions and deliberations.

The Steering Committee of the Health Advisory Network Committee distributed the Interim Report prepared by the Task Force to institutions, agencies, and interested parties in the community on January 24, 1990. Forty (40) responses were received and forwarded to the Task Force in February, 1990. Subsequently seven meetings were held to analyze and consider the responses.

As a consequence, parts of the Interim Report were changed to address concerns, recommendations, and need for clarification. Some recommendations, discussion, and rationale were added.

The Task Force acknowledges that it could not please everyone nor support all points of view.

MEMBERS OF THE TASK FORCE

Ron Birt, Chairman
Eleanor Giffin, Steering Committee Liaison
Colin Lount
Joyce MacFarlane
Evelyn Shapiro
Edith Svanhill

RESOURCE PERSONNEL

Phyllis MacDonald, Recording Secretary
Kay Thomson
Margaret Redston
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CLINICAL ADVISOR

Dr. Paul Henteleff

April, 1990

MANITOBA HEALTH ADVISORY NETWORK

TASK FORCE ON EXTENDED TREATMENT BED REVIEW

DISCUSSION, RECOMMENDATIONS, AND RATIONALE

FOR

WINNIPEG-BASED SERVICES AND INSTITUTIONS

AS AT APRIL, 1990

SUMMARY OF RECOMMENDATIONS AS AT APRIL, 1990

DEFINITIONS

RECOMMENDATION 1 (p. 17)

IT IS RECOMMENDED THAT THE USE OF THE TERM "EXTENDED TREATMENT BEDS" ASSOCIATED WITH THE SUPPLY, USE, AND FUNDING OF INSTITUTIONAL BEDS, BE DISCONTINUED BY PROVINCIAL AUTHORITIES.

RECOMMENDATION 2 (p 18)

For managing the issues associated with the supply, use, and funding of NON-ACUTE beds, IT IS RECOMMENDED THAT THE FOLLOWING DEFINITIONS FOR "REHABILITATION BEDS", "PERSONAL CARE HOME BEDS", AND "CHRONIC CARE BEDS" BE USED BY THE PROVINCIAL AUTHORITIES AND THAT THE FUNDED FACILITIES BE REQUIRED TO USE THEM:

REHABILITATION BEDS

Rehabilitation Beds are of two kinds:

a) those beds required by persons, primarily the elderly, who need rehabilitation or treatment which is of a duration of usually 1 to 6 months because their condition is not amenable to intensive short-term therapy or because the period of recovery is projected to take a long time. The units in which these beds are located often include short-term assessment beds which are used to assess the health status of individuals and/or their rehabilitation potential.

b) those beds in the Rehabilitation Hospital or the Rehabilitation Centre for Children required by persons who need specialized rehabilitation or treatment for complex cases.

PERSONAL CARE HOME BEDS

Personal care home beds are defined as being those beds required by persons who can no longer be cared for at home and whom a multi-disciplinary panel judges as requiring admission to facilities licensed to provide personal care.

CHRONIC CARE BEDS

Chronic care beds are defined as being those beds required by persons who: 1) show little or no potential for rehabilitation, and 2) can no longer be cared for at home or in a personal care home; and 3) require equipment, specialized professional expertise/treatment and/or continuous physician supervision not usually provided in a personal care home.

CHRONIC CARE BEDS

RECOMMENDATION 3 (p. 20)

IT IS RECOMMENDED THAT THE DISTRIBUTION OF CHRONIC CARE BEDS IN WINNIPEG BE AS FOLLOWS:

Winnipeg Municipal Hospital	55
Deer Lodge Centre	131
TOTAL:	186

RECOMMENDATION 4 (p. 20)

IT IS RECOMMENDED THAT THERE BE 40 BEDS WITHIN THE RECOMMENDED CHRONIC CARE BED SUPPLY, FOR THE PROVISION OF CHRONIC CARE TO BRAIN INJURED PERSONS. THE PLACEMENT OF THESE BEDS AS A UNIT SHOULD BE NEGOTIATED WITH THE INVOLVEMENT OF DEER LODGE CENTRE AND WINNIPEG MUNICIPAL HOSPITAL. THE OPENING OF THE BEDS SHOULD BE PHASED IN AS REQUIRED BY SERVICE NEEDS.

RECOMMENDATION 5 (p. 21)

IT IS RECOMMENDED THAT CHRONIC CARE PATIENTS BE PANELLED AS PART OF THE PANELLING OF PERSONAL CARE HOME APPLICANTS. AN ADDITIONAL HEALTH CARE PRACTITIONER WITH SPECIAL EXPERTISE WOULD NEED TO BE ADDED TO THE PANEL ON AN AD HOC BASIS DEPENDING ON THE TYPE OF CHRONIC CARE REQUIRED BY THE PATIENT BEING CONSIDERED BY THE PANEL (E.G., A BRAIN DAMAGED PERSON). ADDITIONAL ASSESSMENTS AND PANELS MAY BE REQUIRED FROM TIME TO TIME TO DEAL WITH THE ADDITIONAL WORKLOAD.

RECOMMENDATION 6 (p. 22)

IT IS RECOMMENDED THAT ADDITIONAL MANPOWER AND FUNDING BE PROVIDED TO CONTINUING CARE TO SUPPORT THE INCLUSION OF THE ASSESSMENT AND PANELLING PROCESSES FOR CHRONIC CARE APPLICANTS, ALLOWING FOR THE NECESSARY EXPERTISE AND EXTRA PANELS AS MAY BE REQUIRED.

RECOMMENDATION 7 (p. 22)

IT IS RECOMMENDED THAT CONTINUING CARE AND THE LONG TERM CARE PROGRAM DIVISION OF THE MANITOBA HEALTH SERVICES COMMISSION REVIEW THE CURRENT PERSONAL CARE HOME APPLICATION AND ASSESSMENT FORM TO FACILITATE ITS USE FOR CHRONIC CARE REFERRAL.

RECOMMENDATION 8 (p. 23)

IT IS RECOMMENDED THAT A COMPUTERIZED MANAGEMENT INFORMATION SYSTEM BE INSTALLED TO PROVIDE TIMELY INFORMATION, FACILITATE DECISION MAKING, AND ASSIST WITH THE PRIORIZATION FOR PLACEMENT OF THE PERSONS ASSOCIATED WITH THE PANELLING PROCESS; THE COMPUTERIZATION OF THE PLACEMENT PROCESS IS A HIGH PRIORITY.

RECOMMENDATION 9 (p. 23)

IT IS RECOMMENDED THAT THERE BE A MANDATORY RE-ASSESSMENT OF CHRONIC CARE PATIENTS IN CHRONIC CARE BEDS ANNUALLY, SIMILAR TO THAT CONDUCTED ON PERSONAL CARE HOME RESIDENTS, TO CONFIRM APPROPRIATE PLACEMENT.

REHABILITATION BEDS

REHABILITATION BEDS PRIMARILY FOR THE ELDERLY (AT LEAST 65 YEARS OF AGE)

RECOMMENDATION 10 (p. 26)

IT IS RECOMMENDED THAT THE REHABILITATION BED SUPPLY, ASSOCIATED PERSONAL CARE HOME ALLOCATED BEDS, AND LOCATIONS BE AS FOLLOWS:

LOCATION	REHABILITATION BEDS		PCH(1) ALLOCATION
Concordia Hospital	0	(2)	(0)
Deer Lodge Centre	67		(25)
Grace General Hospital	0	(3)	(0)
Health Sciences Centre	59		(29)
Misericordia General Hospital	34		(11)
St. Boniface General Hospital	184		(55)
Seven Oaks General Hospital	110		(45)
Winnipeg Municipal Hospital	117		(42)
Victoria General Hospital	12		(4)
Total	583		(211)

NOTES:

(1) The brackets () around the figures in the PCH ALLOCATION column are used to indicate that the allocated bed complement is within the REHABILITATION BEDS for each facility.

(2) See Recommendation 16.

(3) This assumes that Deer Lodge Centre will provide rehabilitation services for the elderly referred by the Grace General Hospital.

RECOMMENDATION 11 (p. 28)

IT IS RECOMMENDED THAT THE SAME PRINCIPLE THAT APPLIES TO ACUTE BEDS APPLY TO REHABILITATION BEDS WITH RESPECT TO THE PLACEMENT OF PERSONS PANELLED FOR PERSONAL CARE HOME PLACEMENT; THAT IS, PRIORITY BE GIVEN TO PLACING PANELLED PERSONS INTO PERSONAL CARE HOMES WHEN REHABILITATION UNITS REACH THE MAXIMUM NUMBER OF PERSONS IN THEIR PERSONAL CARE HOME ALLOCATED BEDS.

RECOMMENDATION 12 (p. 29)

IT IS RECOMMENDED THAT THERE BE DISTRICT REHABILITATION UNITS, EACH TO SERVE A DEFINED GEOGRAPHIC AREA WITH RESPONSIBILITY FOR THE TREATMENT AND/OR TRANSFER OF PERSONS REQUIRING ITS SERVICES FROM ALL HOSPITALS AND COMMUNITIES LOCATED IN ITS AREA.

The Task Force supported the geographic areas concept and the associated institutions as recommended by the geriatricians, namely:

PROPOSED DISTRICT REHABILITATION UNITS:

District	Assessment/Rehabilitation Unit	Associated Institutions
East Winnipeg	St. Boniface Hospital	Concordia Hospital
North Winnipeg	Seven Oaks Hospital	
West Winnipeg	Deer Lodge Centre	Grace General Hospital
South Winnipeg	Wpg. Municipal Hospital	Misericordia Hospital Victoria Hospital
Central Core	Health Sciences Centre	

Note: Health Sciences Centre is to have access to North, South, and West district beds, based on geographic location of patient's domicile.

RECOMMENDATION 13 (p. 31)

IT IS RECOMMENDED THAT EACH DISTRICT REHABILITATION UNIT HAVE A TEAM OF HEALTH PRACTITIONERS IN WHICH THE ASSOCIATED INSTITUTIONS, THE REHABILITATION UNIT, AND CONTINUING CARE IN THE GEOGRAPHIC AREA ARE REPRESENTED TO FACILITATE THE TIMELY ASSESSMENT, SELECTION, CO-ORDINATION, AND ADMISSION OF INDIVIDUALS FOR APPROPRIATE COMMUNITY AND INSTITUTIONAL SERVICES AND TO MONITOR THE RESOURCES ASSOCIATED WITH THE SERVICE DELIVERY.

RECOMMENDATION 14 (p. 31)

IT IS RECOMMENDED THAT EACH DISTRICT REHABILITATION UNIT TEAM BE ACCOMMODATED WITHIN A HOSPITAL WITH THE PROVISION OF THE NECESSARY MANPOWER AND RESOURCES.

RECOMMENDATION 15 (p. 32)

IT IS RECOMMENDED THAT CONTINUING CARE BE PROVIDED WITH ADDITIONAL MANPOWER AND FUNDS AS REQUIRED, TO SERVE ON THE DISTRICT REHABILITATION UNIT TEAMS.

RECOMMENDATION 16 (p. 32)

IT IS RECOMMENDED THAT 20 BEDS WITHIN THE 184 BED REHABILITATION UNIT AT ST. BONIFACE GENERAL HOSPITAL BE SPECIFICALLY DESIGNATED FOR THE EXCLUSIVE USE OF ELDERLY PATIENTS FROM CONCORDIA HOSPITAL WHO REQUIRE REHABILITATION, UNLESS THE TOTAL NUMBER OF REFERRALS DO NOT REQUIRE THE DESIGNATED BEDS AT ANY ONE TIME.

REHABILITATION BEDS FOR SPECIALIZED REHABILITATION OR TREATMENT OF COMPLEX CASES

RECOMMENDATION 17 (p. 33)

IT IS RECOMMENDED THAT NO NEW SUPPLY OF BEDS BE ADDED TO THE 176 BEDS (OF WHICH 22 ARE CLOSED) AT THE HEALTH SCIENCES CENTRE REHABILITATION HOSPITAL.

REHABILITATION OF BRAIN DAMAGED PATIENTS

RECOMMENDATION 18 (p. 34)

IT IS RECOMMENDED THAT A 13-20 BED REHABILITATION UNIT BE LOCATED IN THE HEALTH SCIENCES CENTRE REHABILITATION HOSPITAL FOR BRAIN DAMAGED PATIENTS WITH AN EXPECTED AVERAGE LENGTH OF STAY OF 9 MONTHS.

PERSONAL CARE HOME BEDS

RECOMMENDATION 19 (p. 42)

IT IS RECOMMENDED THAT PERSONAL CARE HOME BED FACILITIES BE BUILT TO SATISFY A 1996 RATIO OF 140 BEDS PER 1,000 POPULATION AGED AT LEAST 75 YEARS FOR WINNIPEG, RESULTING IN APPROXIMATELY 1,442 ADDITIONAL PERSONAL CARE HOME BEDS TO TODAY'S INVENTORY;

HOWEVER, THE FOLLOWING CONDITIONS MUST BE MET:

a) MAINTAINING THE PERSONAL CARE HOME BED ALLOCATION NUMBERS APPROXIMATELY AS THEY CURRENTLY ARE FOR THE ACUTE CARE AND REHABILITATION SERVICES;

b) INSTITUTING POLICY CHANGES TO MINIMIZE TRANSFER DELAYS TO FACILITATE MORE EFFECTIVE REHABILITATION AND ASSESSMENT SERVICES FOR THE ELDERLY; AND,

c) SIGNIFICANTLY INCREASING THE HOME CARE AND OTHER RELATED SERVICE CAPABILITIES;

AND FURTHER:

1. IT IS CRITICAL THAT THE CONDITIONS ASSOCIATED WITH THE ACHIEVEMENT OF THESE BED SUPPLY VOLUMES BE INSTITUTED, WORKING AND EVALUATED BEFORE ANY CONSIDERATION BE GIVEN TO ATTEMPTING TO REDUCE THE RATIO BELOW 140 PERSONAL CARE HOME BEDS PER 1,000 POPULATION AGED AT LEAST 75 YEARS.

2. SINCE NOT ALL OF THE PERSONAL CARE HOME BEDS WILL COME INTO SERVICE AT THE SAME TIME, IT IS IMPERATIVE TO MONITOR THE WAITING LIST AND TO ENSURE THAT THE PROPOSED RATIO IS STILL NECESSARY TO ADDRESS THE NEED.

3. CURRENT PRESSURES FOR PERSONAL CARE HOME BEDS FROM ACUTE CARE AND COMMUNITY SETTINGS ARE EXPECTED TO ESCALATE IN THE SHORT TERM FUTURE. THESE PRESSURES CAN BE RELATED TO THE DROP IN THE RATIO OF PERSONAL CARE HOME BEDS PER 1,000 POPULATION AGED AT LEAST 75 YEARS, FROM 165 IN 1981/82, TO 147 IN 1987/88, TO 140 CURRENTLY. DURING THE PLANNING AND CONSTRUCTION PHASES THE RATIO WILL BE FURTHER REDUCED. HOSPITALS, REHABILITATION UNITS, COMMUNITY SERVICES, PATIENTS, FAMILIES, THE PUBLIC, AND GOVERNMENT WILL HAVE TO ADJUST THEIR EXPECTATION OF HEALTH SERVICES ACCORDINGLY.

RECOMMENDATION 20 (p. 43)

IT IS RECOMMENDED THAT ADDITIONAL MANPOWER AND FUNDS BE MADE AVAILABLE IN CONJUNCTION WITH THE INCREASED DEMANDS FOR PANELLING ANTICIPATED FOR THE INCREASE IN PERSONAL CARE HOME BEDS AND ASSOCIATED OPERATIONAL NEEDS CONCERNING ASSESSMENTS, NUMBER OF PANELS, AND PLACEMENTS.

RECOMMENDATION 21 (p. 43)

IT IS RECOMMENDED THAT THE ADDED PERSONAL CARE HOME BEDS SHOULD BE APPROXIMATELY 44% (635 BEDS) NON-SECULAR, CONSISTENT WITH THE CURRENT SUPPLY RATIO.

RECOMMENDATION 22 (p. 44)

IT IS RECOMMENDED THAT THE ADDED PERSONAL CARE HOME BEDS AND ASSOCIATED PROGRAMMING, AS WELL AS ANY BEING REPLACED, SHOULD BE PREDOMINANTLY FOR HEAVY CARE (LEVELS 3 AND 4) AND INCLUDING THE COGNITIVELY IMPAIRED ELDERLY, SOME OF WHOM REQUIRE LEVEL 2 CARE. IN GEOGRAPHIC AREAS IN WHICH THERE ARE ONLY MULTI-LEVEL (I.E., 2, 3 AND 4) PERSONAL CARE HOMES, CONSIDERATION SHOULD BE GIVEN TO HAVING AT LEAST ONE FACILITY FOR HEAVY CARE.

RECOMMENDATION 23 (p. 45)

IT IS RECOMMENDED THAT PERSONAL CARE HOMES PROVIDE TRAINING AND EDUCATIONAL OPPORTUNITIES FOR STAFF IN THE MANAGEMENT OF THE COGNITIVELY IMPAIRED TO ENSURE APPROPRIATE CARE AND TO REDUCE WORK-RELATED STRESS.

RECOMMENDATION 24 (p. 45)

IT IS RECOMMENDED THAT PERSONAL CARE HOMES ADAPT THEIR TRADITIONAL STAFFING MIX, TYPES OF STAFF, STAFFING PATTERNS, PHYSICAL ENVIRONMENT AND UNIT ORGANIZATION TO MEET THE NEEDS OF THOSE RESIDENTS WHO ARE MOST SEVERELY DYSFUNCTIONAL BECAUSE OF BEHAVIOURS RELATED TO A PSYCHOGERIATRIC CONDITION.

RECOMMENDATION 25 (p. 46)

IT IS RECOMMENDED THAT THE DISTRIBUTION OF THE ADDITIONAL PERSONAL CARE HOME BEDS IN WINNIPEG BE AS FOLLOWS:

DISTRICT/AREA	NUMBER OF BEDS
Fort Rouge, River Heights, East Tuxedo	360
Elmwood, East Kildonan, North Kildonan, East St. Paul	360
West End area bounded by Sherbrook St., Portage Ave., Route 90, & Assiniboine River	360
Undesignated to address specific needs in smaller geographic areas identified by the Manitoba Health Services Commission	362
Total	1,442

RECOMMENDATION 26 (p. 47)

IT IS RECOMMENDED THAT THE HIGHEST PRIORITY FOR PERSONAL CARE HOME BED CONSTRUCTION BE GIVEN TO THE EAST KILDONAN - ELMWOOD - NORTH KILDONAN - EAST ST. PAUL AREA.

RECOMMENDATION 27 (p. 47)

IT IS RECOMMENDED THAT UP TO 230 PERSONAL CARE HOME BEDS OF THE 360 FOR THE FORT ROUGE - RIVER HEIGHTS - EAST TUXEDO AREA BE LOCATED AT THE SITE OF THE WINNIPEG MUNICIPAL HOSPITAL.

RECOMMENDATION 28 (p. 48)

IT IS RECOMMENDED THAT THE NUMBER OF PERSONAL CARE HOME ALLOCATION BEDS BE REDUCED FOR CONCORDIA HOSPITAL FOLLOWING THE CONSTRUCTION OF THE NEW PERSONAL CARE HOME BEDS IN ITS AREA.

PERSONAL CARE HOME BEDS PERTINENT TO THE ACUTE CARE SECTOR

RECOMMENDATION 29 (p. 49)

IT IS RECOMMENDED THAT THERE BE NO CHANGE IN THE TOTAL NUMBER OF PERSONAL CARE HOME BEDS ALLOCATED TO THE ACUTE HOSPITAL BEDS.

RECOMMENDATION 30 (p. 49)

IT IS RECOMMENDED THAT THE MANITOBA HEALTH SERVICES COMMISSION AND THE OFFICE OF CONTINUING CARE REVIEW THE DISTRIBUTION OF PERSONAL CARE HOME ALLOCATED BEDS IN ALL WINNIPEG ACUTE HOSPITALS TO MAKE THE DISTRIBUTION OF THESE BEDS AS EQUITABLE AS POSSIBLE.

RECOMMENDATION 31 (p. 50)

IT IS RECOMMENDED:

(a) THAT THE PERSONAL CARE HOME CHOICE OF THE HOSPITALIZED APPLICANT BE HONORED BUT THAT THE LONGEST WAITING APPLICANTS BE THE FIRST TO BE REQUIRED TO ACCEPT AN INTERIM PLACEMENT (ADDRESSING THE INDIVIDUAL'S SPIRITUAL AND CULTURAL NEEDS WHERE POSSIBLE) IN ANY PERSONAL CARE HOME BED OR REHABILITATION UNIT BED IF THE HOSPITAL HAS THE MAXIMUM NUMBER OF PANELLED PERSONS IN ITS PERSONAL CARE HOME ALLOCATED BEDS BUT IS NOT AT THEIR MAXIMUM OF PERSONAL CARE HOME ALLOCATED BEDS IN THE REHABILITATION UNIT;
HOWEVER, THE INDIVIDUAL TRANSFERRED TO AN INTERIM PERSONAL CARE HOME BED WOULD RETAIN THEIR POSITION ON THE WAITING LIST FOR THE PERSONAL CARE HOME OF THEIR CHOICE UNLESS THEY WITHDREW;

(b) THAT CONTINUING CARE ADOPT A POLICY OF MAKING EVERY ATTEMPT TO PLACE THE LONGEST WAITING PERSONAL CARE HOME PANELLED PATIENTS BEFORE THOSE WAITING LESS TIME, EVEN IF THIS INVOLVES AN INTERIM PLACEMENT; AND,

(c) THAT TO FACILITATE THIS POLICY CHANGE, A PUBLIC EDUCATION PROGRAM FOR THE PROVINCE'S AGENCIES AND THE HOSPITALS BE DEVELOPED TO EXPLAIN THE NEED AND RATIONALE FOR INTERIM PLACEMENT TO PATIENTS AND FAMILIES;

CONTINGENT UPON:

(a) THE ADDITION OF THE REQUIRED NUMBER OF PERSONAL CARE HOME BEDS TO REATTAIN THE RATIO OF 140 BEDS PER 1,000 POPULATION AGED AT LEAST 75 YEARS BY 1992;

(b) AS THEY ARE BROUGHT INTO SERVICE, 20% OF THE NEW BEDS BEING ADDED UNTIL 1996 ARE TO BE SET ASIDE ON A ROTATIONAL BASIS FOR THE EXCLUSIVE USE OF CONTINUING CARE TO PERMIT IT TO MAKE INTERIM PLACEMENTS;

(c) PERSONAL CARE HOMES BEING ENCOURAGED TO ACCOMMODATE INTERIM PLACEMENTS; AND,

(d) THE ADDITION OF THE REQUIRED MANPOWER AND FUNDING TO CONTINUING CARE TO ADDRESS THE RELATED PRESSURES AND NEEDS AS THEY ARISE.

ADULT DISABLED INCLUDING BRAIN DAMAGED PERSONS

RECOMMENDATION 32 (p. 55)

IT IS RECOMMENDED THAT IN THE DEVELOPMENT OF THE PLANS TO INCREASE THE NUMBER OF PERSONAL CARE HOME BEDS IN WINNIPEG, PROVISION BE MADE TO GROUP YOUNG DISABLED ADULTS IN APPROPRIATE SETTINGS WHERE IT WOULD BE CONSIDERED TO BE BENEFICIAL TO THEIR CARE AND LIFESTYLE, AND THAT IN CONJUNCTION WITH THIS, TRANSFERS OF YOUNG ADULTS BE FACILITATED INTO THESE SETTINGS ONCE AVAILABLE.

RECOMMENDATION 33 (p. 56)

IT IS RECOMMENDED THAT THE USE OF TEN TEN SINCLAIR TO PROVIDE THE TRANSITIONAL FACILITY NEEDS OF BRAIN DAMAGED PERSONS BE CONSIDERED BEFORE CONSIDERING ANY PROPOSAL TO BUILD AND OPERATE ANY ASSOCIATED NEW UNIT.

RECOMMENDATION 34 (p. 57)

IT IS RECOMMENDED THAT ENCOURAGEMENT AND FUNDING BE PROVIDED FOR THE CONTINUED DEVELOPMENT OF FACILITIES AND PROGRAMS SIMILAR TO THOSE OF THE FOKUS UNITS ADMINISTERED BY TEN TEN SINCLAIR HOUSING INC. AS THE NEED ARISES.

DAY CARE PROGRAM

RECOMMENDATION 35 (p. 58)

IT IS RECOMMENDED THAT THE NUMBER OF DAY CARE PROGRAM SPACES BE INCREASED TO SUPPORT THE AVOIDANCE AND DEFERRAL OF INSTITUTIONALIZATION OF THE ELDERLY FOR AS LONG AS APPROPRIATELY POSSIBLE.

CONTINUING CARE PROGRAM

RECOMMENDATION 36 (p. 59)

IT IS RECOMMENDED THAT THE CONTINUING CARE PROGRAM BE FUNDED ON AN ADEQUATE BASIS TO ENSURE THAT IT CAN FULFILL THE EXPANDED FUNCTIONS AS DETAILED IN THIS REPORT IN ADDITION TO ITS CURRENT RESPONSIBILITIES.

RECOMMENDATION 37 (p. 59)

IT IS RECOMMENDED THAT ADDITIONAL FUNDS BE ALLOCATED TO THE CONTINUING CARE PROGRAM BEYOND THOSE OUTLINED IN RECOMMENDATION 36 TO ENABLE THE PROGRAM TO FUNCTION ON A 7 DAY-A-WEEK, 24 HOUR DAY BASIS IN ORDER TO ENSURE THAT THE MAXIMUM NUMBER OF HOSPITAL DISCHARGES AND PERSONS AWAITING PLACEMENT IN ACUTE BEDS, REHABILITATION BEDS AND IN THE COMMUNITY CAN BE CARED FOR AT HOME.

THE REQUESTS OF CONCORDIA HOSPITAL AND GRACE HOSPITAL FOR NON-ACUTE CARE BEDS

Concordia Hospital

Concordia Hospital had requested 60 beds for non-acute care as follows:

30 - rehabilitation of the elderly
20 - persons awaiting placement in a personal care home
5 - chronic care
5 - intermittent admission and respite care

In conjunction with its recommendations, the Task Force concluded that the hospital's and community's needs would be met by other means for the following reasons:

1. Concordia Hospital's most serious problem is that it has a higher number of Personal Care Home Allocated Beds relative to the total number of acute beds and that these beds are often filled close to, or at, maximum capacity. Giving Concordia Hospital's catchment area priority for new personal care home bed construction would help to alleviate this problem and could result in a reduction in the Hospital's Personal Care Home Allocated Beds. This would increase its acute bed capacity.

2. Concordia Hospital's next most serious problem is the transfer of elderly persons requiring long-term rehabilitation. Giving the Hospital access to 20 such beds at St. Boniface General Hospital and to geriatric assessment expertise as recommended by the Heads of Geriatric Services, would alleviate this problem and provide better service to patients as well as avoiding an increase in an already adequate supply of beds.

3. In terms of numbers, Concordia Hospital does not have a serious problem in transferring persons requiring chronic care. Also, dispersion of specialized, difficult to recruit, staff among an increased number of units would be counter-productive. Further, the use of the proposed panels to assure appropriate priority labelling and transferring of persons requiring chronic care would serve the Hospital's needs.

4. Winnipeg Municipal Hospital already has considerable expertise and the programs for chronic care services and Deer Lodge Centre has vacant beds available for occupancy.

Grace General Hospital

Grace General Hospital's request for 60 non-acute care beds was as follows:

30 - level 2 care for persons awaiting personal care home placement
30 - levels 3 and 4 care for persons awaiting personal care home placement

The Task Force again concluded that the Hospital's and community's needs would best be met by other means for the following reasons:

1. Grace General Hospital does not have a problem transferring elderly persons or others requiring rehabilitation services since it has a good working relationship with Deer Lodge Centre and the proposed new system should be even more responsive to its needs.

2. Grace General Hospital has not used its total maximum of personal care home allocated bed capacity and its catchment area is not short of personal care home beds.

3. Grace General Hospital, in common with Concordia Hospital, has few persons awaiting admission to chronic care beds. Again, the shortage and dispersal of the specialized staff required would mean a chronic care unit at the Grace General Hospital would be less viable than locating such beds at Winnipeg Municipal Hospital and Deer Lodge Centre.

4. Winnipeg Municipal Hospital already has considerable expertise and the programs for chronic care services and Deer Lodge Centre has vacant beds available for occupancy.

DISCUSSION, RECOMMENDATIONS, AND RATIONALE

DEFINITIONS

The Task Force noted that the Manitoba Health Services Commission did not have a definition of "extended treatment" although it did share definitions of various components of extended treatment programs with Manitoba health facilities (September 28, 1984). It also appears that there is not a working definition of "extended treatment" at the federal level.

The lack of a definition for "extended treatment" posed an immediate challenge for the Task Force in addressing its assignments. In addition, there are nationally established definitions for "long-term care" and "rehabilitation" which had to be considered. The Force was also sensitive to the facilities' preferences for providing their own program names.

Consequently, the Task Force decided to propose 3 definitions under the general heading or classification of "NON-ACUTE BEDS" for purposes of dealing with matters pertinent to managing the supply and funding of the associated beds, regardless of the local facility program name.

RECOMMENDATION 1:

In conjunction with this purpose it is RECOMMENDED THAT THE USE OF THE TERM "EXTENDED TREATMENT BEDS" ASSOCIATED WITH THE SUPPLY, USE, AND FUNDING OF INSTITUTIONAL BEDS, BE DISCONTINUED BY PROVINCIAL AUTHORITIES.

RECOMMENDATION 2:

For managing the issues associated with the supply, use, and funding of NON-ACUTE beds, IT IS RECOMMENDED THAT THE FOLLOWING DEFINITIONS FOR "REHABILITATION BEDS", "PERSONAL CARE HOME BEDS", AND "CHRONIC CARE BEDS" BE USED BY THE PROVINCIAL AUTHORITIES AND THAT THE FUNDED FACILITIES BE REQUIRED TO USE THEM:

REHABILITATION BEDS

Rehabilitation Beds are of two kinds:

a) those beds required by persons, primarily the elderly, who need rehabilitation or treatment which is of a duration of usually 1 to 6 months because their condition is not amenable to intensive short-term therapy or because the period of recovery is projected to take a long time. The units in which these beds are located often include short-term assessment beds which are used to assess the health status of individuals and/or their rehabilitation potential.

b) those beds in the Rehabilitation Hospital or the Rehabilitation Centre for Children required by persons who need specialized rehabilitation or treatment for complex cases.

PERSONAL CARE HOME BEDS

Personal care home beds are defined as being those beds required by persons who can no longer be cared for at home and whom a multi-disciplinary panel judges as requiring admission to facilities licensed to provide personal care.

CHRONIC CARE BEDS

Chronic care beds are defined as being those beds required by persons who: 1) show little or no potential for rehabilitation; and 2) can no longer be cared for at home or in a personal care home; and 3) require equipment, specialized professional expertise/treatment and/or continuous physician supervision not usually provided in a personal care home.

CHRONIC CARE BEDS

Current Chronic Bed Supply in Winnipeg:

Deer Lodge Centre	64
Winnipeg Municipal Hospital	142
TOTAL	206

Projected Chronic Care Bed Requirements in Winnipeg:

Total existing chronic care beds	206	
Add beds needed for brain damaged and head injury persons awaiting chronic care in acute care and rehabilitation settings	25	
Less PCH allocation at Winnipeg Municipal Hospital	(45)	(1)
TOTAL CHRONIC CARE BEDS REQUIRED FOR WINNIPEG:	186	

(1) The personal care home bed allocations are discussed in conjunction with the acute care and rehabilitation beds in the Personal Care Home section of this Report.

Options in Addressing the Supply of Chronic Care Beds:

Option 1 - Deer Lodge Centre -

The Task Force was aware of the potential to develop the seventh floor, accommodating up to 44 beds, at Deer Lodge Centre; however, the availability of the 90 unopened beds elsewhere in the Centre and the overall chronic care bed needs for Winnipeg precluded this option.

Option 2 - Concordia Hospital -

The Task Force considered placing 60 chronic care beds at Concordia Hospital and reducing the number of chronic care beds at Winnipeg Municipal Hospital. Under this proposal 62 beds would be retained at the Winnipeg Municipal Hospital. Taking this into account, together with the beds at Deer Lodge Centre, the distribution of chronic care beds in Winnipeg would become:

Deer Lodge Centre	64
Winnipeg Municipal Hospital	62
Concordia Hospital	60
TOTAL:	186

The Task Force did not consider this to be a viable option for the following reasons:

1) In relation to the history and established skills of Deer Lodge Centre and Winnipeg Municipal Hospital and the national shortage of specialized expertise, a significant change in role for Concordia Hospital was not considered to be appropriate.

2) The establishment of a 60-bed chronic care facility at Concordia Hospital would not address its needs in terms of the patients awaiting transfer to a personal care home. In the functional plan for the hospital's expansion, it was proposed that there be only a small chronic care service based on 5 beds.

RECOMMENDATION 3:

IT IS RECOMMENDED THAT THE DISTRIBUTION OF CHRONIC CARE BEDS IN WINNIPEG BE AS FOLLOWS:

Winnipeg Municipal Hospital	55
Deer Lodge Centre	131
TOTAL:	186

Rationale:

1) The extensive history and expertise of the institutions in the management and provision of chronic care is acknowledged.

2) Flexibility is retained with regard to the placement of a unit to provide for the chronic care needs of brain damaged patients by one or the other of the two facilities.

3) The recommended bed distribution was influenced by the configuration of unopened beds set up at Deer Lodge Centre.

RECOMMENDATION 4:

IT IS RECOMMENDED THAT THERE BE 40 BEDS WITHIN THE RECOMMENDED CHRONIC CARE BED SUPPLY, FOR THE PROVISION OF CHRONIC CARE TO BRAIN DAMAGED PERSONS. THE PLACEMENT OF THESE BEDS AS A UNIT SHOULD BE NEGOTIATED WITH THE INVOLVEMENT OF DEER LODGE CENTRE AND WINNIPEG MUNICIPAL HOSPITAL. THE OPENING OF THE BEDS SHOULD BE PHASED IN AS REQUIRED BY SERVICE NEEDS.

Rationale and Discussion:

1. The 40 beds would accommodate the 8 brain damaged patients currently being cared for at the Winnipeg Municipal Hospital as well as approximately 25 others, including the 20 in the Health Sciences Centre, awaiting care in acute care and rehabilitation settings in other Winnipeg hospitals.

2. The Task Force identified several difficulties in determining chronic care bed needs of brain damaged patients for 1996:

   - the proportionate increase of the elderly population in relation to the younger population will have an as yet undetermined effect on the incidence of trauma and brain injury in the young; or stated another way--the number of persons in the age group which is most at risk of having serious trauma injuries is decreasing. It is difficult, therefore, to predict if the number of persons affected will drop or whether the accident rate will increase.

   - due to the unconfirmed future demands for chronic care beds in support of brain damaged patients, THIS ISSUE SHOULD BE RE-EXAMINED IN FIVE YEARS.

RECOMMENDATION 5:

IT IS RECOMMENDED THAT CHRONIC CARE PATIENTS BE PANELLED AS PART OF THE PANELLING OF PERSONAL CARE HOME APPLICANTS. AN ADDITIONAL HEALTH CARE PRACTITIONER WITH SPECIAL EXPERTISE WOULD NEED TO BE ADDED TO THE PANEL ON AN AD HOC BASIS DEPENDING ON THE TYPE OF CHRONIC CARE REQUIRED BY THE PATIENT BEING CONSIDERED BY THE PANEL (E.G., A BRAIN DAMAGED PERSON). ADDITIONAL ASSESSMENTS AND PANELS MAY BE REQUIRED FROM TIME TO TIME TO DEAL WITH THE ADDITIONAL WORKLOAD.

Rationale and Discussion:

With respect to the process for gaining admission to personal care homes, the individual, the family, or any health professional may make a referral to Continuing Care for assessment of need for placement. The process includes:

a) assessment of need by Continuing Care staff.
b) approval by a multi-disciplinary panel that the person requires placement in a personal care home.
c) establishment of the priority of need for placement by the assessment panel.
d) agreement by the personal care home that the person's care can be managed.

The benefits of putting this process in place for chronic care patients would be that:

a) It would establish a waiting list, criteria, and a more systematic approach to appropriate placement of individuals requiring chronic care from institutions and the community.
b) It ensures appropriate placement of patients in chronic care beds.
c) It establishes placement on a priority basis.
d) It facilitates a more appropriate bed utilization which will allow better use of institutional beds.
e) It allows for improved quality of service as patients would be transferred through a more appropriate placement process under one panel with consolidated decision making and less risk of having placement delays associated with referring patients from one decision making body to another.
f) It facilitates rational planning for programs and related budgets; for example, the number of patients awaiting specific programs may identify a need for reallocation of resources.
g) In combination with the proposed supply of 186 chronic care beds, the panelling process should alleviate the congestion of chronic care patients being experienced by acute care hospitals.

RECOMMENDATION 6:

IT IS RECOMMENDED THAT ADDITIONAL MANPOWER AND FUNDING BE PROVIDED TO CONTINUING CARE TO SUPPORT THE INCLUSION OF THE ASSESSMENT AND PANELLING PROCESSES FOR CHRONIC CARE APPLICANTS, ALLOWING FOR THE NECESSARY EXPERTISE AND EXTRA PANELS AS MAY BE REQUIRED.

RECOMMENDATION 7:

IT IS RECOMMENDED THAT CONTINUING CARE AND THE LONG TERM CARE DIVISION OF THE MANITOBA HEALTH SERVICES COMMISSION REVIEW THE CURRENT PERSONAL CARE HOME APPLICATION AND ASSESSMENT FORM TO FACILITATE ITS USE FOR CHRONIC CARE REFERRAL.

RECOMMENDATION 8:

IT IS RECOMMENDED THAT A COMPUTERIZED MANAGEMENT INFORMATION SYSTEM BE INSTALLED TO PROVIDE TIMELY INFORMATION, FACILITATE DECISION MAKING, AND ASSIST WITH THE PRIORIZATION FOR PLACEMENT OF THE PERSONS ASSOCIATED WITH THE PANELLING PROCESS; THE COMPUTERIZATION OF THE PLACEMENT PROCESS IS A HIGH PRIORITY.

RECOMMENDATION 9:

IT IS RECOMMENDED THAT THERE BE A MANDATORY RE-ASSESSMENT OF CHRONIC CARE PATIENTS IN CHRONIC CARE BEDS ANNUALLY, SIMILAR TO THAT CONDUCTED ON PERSONAL CARE HOME RESIDENTS, TO CONFIRM APPROPRIATE PLACEMENT.

Rationale:

1. As suggested by the Task Force on Health Services for the Elderly in its response to the Interim Report, the regular review of all chronic care patients would help to ensure that appropriate changes in resources are identified and implemented according to the patients' changing conditions.

REHABILITATION BEDS

Discussion and Recommendations Concerning Rehabilitation Beds Primarily for the Elderly (At least 65 Years of Age)

The Committee reviewed the rehabilitation bed supply and concerns associated with the movement of persons from acute beds or from the community into rehabilitation beds. The major problems identified were:

1. Delays in transferring persons from acute to rehabilitation beds can impede recovery.

2. No system exists to priorize and expedite transfers from acute to rehabilitation units, leaving some hospitals and some geographic areas less equitably served.

3. Personal Care Home Allocated Beds in rehabilitation units appear to be disproportionately distributed.

A meeting at which these problems were shared with the Heads of Geriatric Services resulted in a series of proposals to resolve these problems. These proposals were taken into account in the formulation of the Task Force's recommendations.

The current rehabilitation bed supply primarily for the elderly is:

LOCATION	REHABILITATION BEDS		PCH ALLOCATION
Concordia Hospital	0		(0)
Deer Lodge Centre	44		(0)
Grace General Hospital	0	(1)	(0)
Health Sciences Centre	59		(23)
Misericordia General Hospital	34		(0)
St. Boniface General Hospital	184		(55)
Seven Oaks General Hospital	110		(55)
Victoria General Hospital	12		(0)
Winnipeg Municipal Hospital	195	(2)	(91)
Total	638	(3)	(224)
Less PCH Allocated	224		
TOTAL SUPPLY	414		

NOTES:

(1) The brackets () around the figures in the PCH ALLOCATION column are used to indicate that the allocated bed complement is within the REHABILITATION BEDS complement for each facility. Other tables in this Report make similar use of the brackets to indicate bed complement relationships.

(2) There is an arrangement for the rehabilitation service needs of the elderly in the Grace General Hospital to be provided by Deer Lodge Centre.

(3) This includes 173 assessment/rehabilitation beds and 22 respiratory beds.

(4) Personal Care Home allocated beds are 35% of total beds.

In 1986 based on the population of 73,200 the total rehabilitation bed supply (638) minus the Personal Care Home allocated beds (224) was 414 beds or 5.7 per 1,000 elderly aged at least 65 years. Similarly, for a projected population of 89,100 in 1996 and maintaining the 414 beds, the ratio of rehabilitation beds would be 4.6 per 1,000 elderly aged at least 65 years.

In contrast, the Personal Care Home beds where the average age at admission is 75 years or more, the average age of elderly persons using rehabilitation services is younger; therefore, bed ratios are calculated in relation to 1,000 population aged at least 65 years.

There is no national or international consensus on bed definitions and optimum rehabilitation bed ratios. Only the two Western Provinces, Alberta and Saskatchewan, were able to provide data on rehabilitation/assessment beds per population aged at least 65 years. Ontario does not designate or keep data on specific geriatric rehabilitation beds. The data obtained for Edmonton was 4.2 beds per 1,000 for persons aged at least 65 years and Saskatoon 2.0 beds per 1,000. With the unavailability of other data and considering those available, the projected 1996 rehabilitation bed supply ratio of 4.6 per 1,000 in Winnipeg appears adequate.

RECOMMENDATION 10:

IT IS RECOMMENDED THAT THE REHABILITATION BED SUPPLY, ASSOCIATED PERSONAL CARE HOME ALLOCATED BEDS, AND LOCATIONS BE AS FOLLOWS:

LOCATION	REHABILITATION BEDS		PCH ALLOCATION (1)
Concordia Hospital	0	(2)	(0)
Deer Lodge Centre	67		(25)
Grace General Hospital	0	(3)	(0)
Health Sciences Centre	59		(29)
Misericordia General Hospital	34		(11)
St. Boniface General Hospital	184		(55)
Seven Oaks General Hospital	110		(45)
Winnipeg Municipal Hospital	117		(42)
Victoria General Hospital	12		(4)
TOTAL	583		(211)

NOTES:

(1) The brackets () around the figures in the PCH ALLOCATION column are used to indicate that the allocated bed complement is within REHABILITATION BEDS for each facility.

(2) See Recommendation 16.

(3) This assumes that Deer Lodge Centre will provide rehabilitation services for the elderly referred by the Grace General Hospital.

Rationale:

1. This option provides slightly fewer beds and slightly fewer Personal Care Home allocated beds but uses all available, unopened beds at Deer Lodge which are not used for chronic care and still provides 4.2 beds per 1,000 aged at least 65 years in 1996.

2. It redistributes the Personal Care Home beds more proportionately among the hospitals' rehabilitation units than before.

3. It provides a maximum of 36% of the rehabilitation beds (in line with the geriatricians' recommendation) for persons who, despite rehabilitation efforts, do not improve enough to return home and, therefore, require Personal Care Home placement.

4. Some pertinent statistical elements associated with the recommendation are:

   4.1 Ratio of Personal Care Home Allocated Beds to Rehabilitation Beds = 36%.

   4.2 372 (583-211) beds for the 1986 population aged at least 65 years equates to 5.1 per 1,000 population.

   4.3 372 beds for the projected 1996 population aged at least 65 years equates to 4.2 per 1,000 population.

5. Among several other options, the following one, providing substantially fewer total beds than the recommended option, was discussed but rejected on the grounds that the ratio of Personal Care Home beds per 1,000 elderly aged at least 75 years was dropping so quickly that the 36% Personal Care Home allocation might have to be used to maximum capacity pending Personal Care Home bed construction.

LOCATION	REHABILITATION BEDS	PCH ALLOCATION
Concordia Hospital	0	(0)
Deer Lodge Centre	67	(25)
Grace General Hospital	0	(0)
Health Sciences Centre	59	(23)
Misericordia General Hospital	34	(12)
St. Boniface General Hospital	184	(55)
Seven Oaks General Hospital	110	(45)
Winnipeg Municipal Hospital	77	(26)
Victoria General Hospital	12	(4)
TOTAL	543	(190)*

* Note that, in addition to providing fewer total beds, this option also provides fewer Personal Care Home allocated beds than the recommended option.

The statistical elements for this option, similar to those referenced in rationale item 4., are:

5.1 Ratio of Personal Care Home Allocated Beds to Rehabilitation Beds = 35%.

5.2 353 (543-190) Beds for the 1986 population aged at least 65 years equates to 4.7 per 1,000 population.

5.3 353 Beds for the projected 1996 population aged at least 65 years equates to 4.0 per 1,000 population.

RECOMMENDATION 11:

IT IS RECOMMENDED THAT THE SAME PRINCIPLE THAT APPLIES TO ACUTE BEDS APPLY TO REHABILITATION BEDS WITH RESPECT TO THE PLACEMENT OF PERSONS PANELLED FOR PERSONAL CARE HOME PLACEMENT; THAT IS, PRIORITY BE GIVEN TO PLACING PANELLED PERSONS INTO PERSONAL CARE HOMES WHEN REHABILITATION UNITS REACH THE MAXIMUM NUMBER OF PERSONS IN THEIR PERSONAL CARE HOME ALLOCATED BEDS.

Discussion and Rationale:

1. The optimal use of rehabilitation beds needs to be facilitated in view of the units' expanded role in serving all areas of Winnipeg.

2. Because these units accept persons at risk of losing their capability for independence, they are likely to have more persons who, despite all efforts, cannot return home.

3. It is assumed that placing the high priority panelled persons from the community will get equal priority to those from the rehabilitation beds.

RECOMMENDATION 12:

IT IS RECOMMENDED THAT THERE BE DISTRICT REHABILITATION UNITS, EACH TO SERVE A DEFINED GEOGRAPHIC AREA WITH RESPONSIBILITY FOR THE TREATMENT AND/OR TRANSFER OF PERSONS REQUIRING ITS SERVICES FROM ALL HOSPITALS AND COMMUNITIES PLOCATED IN ITS AREA.

The Task Force supported the geographic areas concept and the associated institutions as recommended by the geriatricians, namely:

PROPOSED DISTRICT REHABILITATION UNITS:

District	Assessment/Rehabilitation Unit	Associated Institutions
East Winnipeg	St. Boniface Hospital	Concordia Hospital
North Winnipeg	Seven Oaks Hospital	
West Winnipeg	Deer Lodge Centre	Grace General Hospital
South Winnipeg	Wpg. Municipal Hospital	Misericordia Hospital Victoria General Hospital
Central Core	Health Sciences Centre	

Note: Health Sciences Centre is to have access to North, South, and West district beds, based on geographic location of patient's domicile.

Discussion and Rationale:

1. This provides all the urban hospitals with common access to rehabilitation services in their geographic area based on priority of need for rehabilitation unit services.

2. It would provide the hospitalized or community persons access to the rehabilitation services in their geographic area through a common referral process.

3. The purpose of the District Rehabilitation Units is to facilitate the assessment, rehabilitation, treatment, and placement of primarily elderly persons, avoiding wherever possible institutional placement through utilization of appropriate community resources.

4. The Task Force agrees with a response to the Interim Report which suggested that it would not be economical nor practical to expect each district rehabilitation unit to provide a complete spectrum of service for its district. This means that where expertise within the field at a particular unit is developed and acknowledged, that unit could serve as a referral unit for the others. A service network could be appropriately developed without unnecessary and costly duplication.

5. Respondents to the Interim Report also indicated a need for the rehabilitation units to maintain a flexible stance so that patients or clientele could be moved or referred between respective units to accommodate geographic location of families or to access specific/unique services of a facility. The Task Force believes this to be necessary and desirable.

RECOMMENDATION 13:

IT IS RECOMMENDED THAT EACH DISTRICT REHABILITATION UNIT HAVE A TEAM OF HEALTH PRACTITIONERS IN WHICH THE ASSOCIATED INSTITUTIONS, THE REHABILITATION UNIT, AND CONTINUING CARE IN THE GEOGRAPHIC AREA ARE REPRESENTED TO FACILITATE THE TIMELY ASSESSMENT, SELECTION, CO-ORDINATION, AND ADMISSION OF INDIVIDUALS FOR APPROPRIATE COMMUNITY AND INSTITUTIONAL SERVICES AND TO MONITOR THE RESOURCES ASSOCIATED WITH THE SERVICE DELIVERY.

Rationale:

1. The primary purpose of the rehabilitation team is to facilitate timely assessment and placement of individuals and optimal service utilization.

2. This would provide a city-wide, common and equitable system for access to units which have the requisite expertise.

3. The composition of the rehabilitation unit teams would facilitate close communication between the relevant components of health care delivery and the making of appropriate decisions in regard to the rehabilitation needs of all hospitals.

4. It provides geriatric consultation services to all hospitals.

5. It facilitates access to rehabilitation services primarily for the elderly within hospitals which have small rehabilitation units.

RECOMMENDATION 14

IT IS RECOMMENDED THAT EACH DISTRICT REHABILITATION UNIT TEAM BE ACCOMMODATED WITHIN A HOSPITAL WITH THE PROVISION OF THE NECESSARY MANPOWER AND RESOURCES.

Rationale:

1. Budgetary provision would have to be made for such items as the clerical, correspondence, and supplies elements necessary to assist the district rehabilitation teams.

RECOMMENDATION 15

IT IS RECOMMENDED THAT CONTINUING CARE BE PROVIDED WITH ADDITIONAL MANPOWER AND FUNDS AS REQUIRED, TO SERVE ON THE DISTRICT REHABILITATION UNIT TEAMS.

Rationale:

Continuing Care staff and funds are currently not budgeted for these items.

RECOMMENDATION 16

IT IS RECOMMENDED THAT 20 BEDS WITHIN THE 184 BED REHABILITATION UNIT AT ST. BONIFACE GENERAL HOSPITAL BE SPECIFICALLY DESIGNATED FOR THE EXCLUSIVE USE OF ELDERLY PATIENTS FROM CONCORDIA HOSPITAL WHO REQUIRE REHABILITATION, UNLESS THE TOTAL NUMBER OF REFERRALS DO NOT REQUIRE THE DESIGNATED BEDS AT ANY ONE TIME.

Discussion and Rationale:

1. Concordia Hospital medical staff already have a close working liaison with the St. Boniface General Hospital rehabilitation unit's staff.

2. The recommendation does permit the use of some of the 20 beds for other patients with similar needs in the East Winnipeg District in the event that there are no demands for the bed-based services for patients from Concordia Hospital.

3. Although both hospitals objected to an earlier version of this recommendation in the Interim Report, the Task Force believes it is more cost-effective and more conserving of scarce professional resources and expertise to use rehabilitation beds located in one unit for the whole geographic area, such as exists for the rehabilitation services involving Deer Lodge Centre and the Grace General Hospital.

REHABILITATION BEDS
FOR
SPECIALIZED REHABILITATION OR TREATMENT OF COMPLEX CASE

RECOMMENDATION 17

IT IS RECOMMENDED THAT NO NEW SUPPLY OF BEDS BE ADDED TO THE 176 BEDS (OF WHICH 22 ARE CLOSED) AT THE HEALTH SCIENCES CENTRE REHABILITATION HOSPITAL.

Rationale:

1. There are 176 rated beds of which the hospital was given approval to close 22 respiratory beds; there is also a request to close an additional 12 beds within the rehabilitation services section; however, with respect to the Task Force's deliberations and recommendations, the potential for the full complement of 176 beds remains.

2. A comparison of the ratios for this kind of rehabilitation beds available for the population in cities of comparable size to Winnipeg indicates that our supply is similar to, or greater than, other cities. This is the case even if proposed changes for the Health Sciences Centre Rehabilitation Hospital to accommodate a day hospital by reducing current bed numbers by 12 were approved. As an example, the Task Force learned that rehabilitation beds with functions similar to those at the Rehabilitation Hospital were available as follows in Ontario; 132 in London, 181 in Hamilton, and 129 in Ottawa (which are shared with Kingston).

3. While the occupancy rate for the respiratory unit (22 beds) is 96%, the occupancy rate for the rest of the hospital, less beds which are currently not in use, is 73%.

RECOMMENDATION 18

IT IS RECOMMENDED THAT A 13-20 BED REHABILITATION UNIT BE LOCATED IN THE HEALTH SCIENCES CENTRE REHABILITATION HOSPITAL FOR BRAIN DAMAGED PATIENTS WITH AN EXPECTED AVERAGE LENGTH OF STAY OF 9 MONTHS.

Discussion and Rationale:

1. The other options considered were to add beds to the existing but undeveloped seventh floor at Deer Lodge or to add beds in the redevelopment at Winnipeg Municipal Hospital. However, the bed supply and occupancy rate at the Rehabilitation Hospital suggest that persons could be accommodated there without constructing an entirely new facility.

2. The medical expertise required for such persons is currently concentrated at the Rehabilitation Hospital.

3. The number of persons in the age group which is most at risk of having serious trauma injuries is decreasing. It is difficult, therefore, to predict if the number of persons affected will drop or whether the accident rate will increase.

4. Since Dr. N. Hill recently suggested the average rehabilitation time is 9 months, the number of beds required may be less than 13-20 as originally suggested in Dr. Hill's report dated August 30, 1989.

5. Subsequent to intensive therapy at the Rehabilitation Hospital individuals are often returned to the acute care hospital after it is obvious they are unable to return to the community. However, an acute hospital is an inappropriate place for continued rehabilitation.

6. According to Dr. N. Hill's report of August 9, 1989, it is extremely important "that during the first 9-12 months (after the acute phase of treatment is over) everything possible should be done and they (the brain damaged patients) should receive the most modern rehabilitation treatment".

7. In January 1989, a survey of the two teaching hospitals indicated there were 13 patients who had been in hospital for less than one year but who would be eligible for a rehabilitation unit. It may be that there were also such patients in other hospitals, indicating a need for a 13-20 bed unit.

PERSONAL CARE HOME BEDS

1. CURRENT BED SUPPLY - Excluding hostel beds but including beds approved for construction as at November 1, 1989 there is provision for 4,452 personal care home beds in Winnipeg; this equates to a bed supply ratio of 140 per 1,000 population aged at least 75 years, based on M.H.S.C. June 1988 data.

2. DEMOGRAPHICS AND 1996 BED SUPPLY PROJECTIONS -

1987/88 POPULATION AGED AT LEAST 75 YEARS - WINNIPEG (Source - 1987/88 MHSC Annual Report)	30,846
1987/88 PERSONAL CARE HOME BEDS - WINNIPEG (Source - 1987/88 MHSC ANNUAL REPORT)	4,532

BED SUPPLY RATIO - 147 PER 1,000 POPULATION AGED AT LEAST 75 YEARS (1987/88)

1987/88 PROVINCIAL POPULATION AGED AT LEAST 75 YEARS (source - 1987/88 MHSC ANNUAL REPORT)	56,663
1987/88 PROPORTION OF WINNIPEG TO PROVINCIAL POPULATION AGED AT LEAST 75 YEARS	54.5%
JUNE, 1988 POPULATION AGED AT LEAST 75 YEARS - WINNIPEG (Source - MHSC Registration File)	31,900
JUNE, 1988 PROVINCIAL POPULATION AGED AT LEAST 75 YEARS (Source - MHSC Registration File)	58,430
JUNE, 1988 PROPORTION OF WINNIPEG TO PROVINCIAL POPULATION AGED AT LEAST 75 YEARS	54.6%
NOVEMBER 1, 1989 PERSONAL CARE HOME BED SUPPLY (excludes hostel beds but includes beds approved for construction as at November 1, 1989)	4,452

BED SUPPLY RATIO - 140 PER 1,000 POPULATION AGED AT LEAST 75 YEARS (JUNE 1988)

POPULATION PROJECTIONS FOR MANITOBA - 1986 TO 1996 - FOR PERSONS AGED AT LEAST 75 YEARS:

1986 - 1991 FROM 56,600 TO 65,200 AN INCREASE OF 8,600

1991 - 1996 FROM 65,200 TO 73,700 AN INCREASE OF 8,500

(Source - M.H.S.C. June 1987 actual and percentage change, as projected by the Economic Resource and Investment Committee of Cabinet, population projections are based on Statistics Canada 14LC, Demography Division, "Population Projections by Sex and Age Group - Canada and the Provinces 1983 - 2006)

POPULATION PROJECTIONS FOR WINNIPEG - 1986 TO 1996 - FOR PERSONS AGED AT LEAST 75 YEARS

(assumes the proportion of Winnipeg residents to Manitoba residents for this age category will be approximately 57.8% in 1996; source - MANITOBA BUREAU OF STATISTICS)

1986-1991 FROM 31,130 TO 35,860	AN INCREASE OF	4,730
1991-1996 FROM 35,860 TO 42,100	AN INCREASE OF	6,240
TOTAL GROWTH PROJECTED		10,970
PROJECTION FOR 1996 WINNIPEG POPULATION AGED AT LEAST 75 YEARS		42,100

BED SUPPLY PROJECTIONS

According to various bed supply per 1,000 population ratios, the anticipated increase in beds required in Winnipeg for 1996 over the current supply of 4,452 would be:

Beds/1,000 Pop.	Total Beds	Required Increase
144	6,062	1,610
140	5,894	1,442
135	5,684	1,232
110	4,631	179
106	4,452	0

3. PLACEMENT PROCESSES - By "panelling" suitable candidates, Continuing Care manages the personal care home placement process with the involvement of the personal care homes, other institutions and community services personnel. There is an attempt to balance the admissions from the community with those from the institutions in order to reduce the number of persons

having to go through the institutions before entering the personal care home. Hospital applications are chronologically dated and managed in that order unless there is related bed occupancy pressure from one particular institution. There is continual pressure to transfer panelled persons from the institutions to the personal care homes to achieve optimal use of the acute care and rehabilitation beds. Community cases are prioritized on an as needed basis according to individual case circumstance. Given the 96% to 98% occupancy rate and an average length of stay of 4 years, admission rates to the personal care homes is essentially determined by the number of deaths occurring in the homes in any given time period.

4. WAITING LISTS - Task Force consultations with Continuing Care personnel indicated that there are currently 650 to 700 panelled persons listed as waiting placement in a personal care home from month to month. Of these, approximately 400-450 are in acute care and rehabilitation beds (Task Force definitions used) with the balance in the community.

5. ALLOCATED BEDS - Within the Winnipeg institutions, the Manitoba Health Services Commission has allocated a total of 434 beds for persons awaiting placement in personal care homes. Of these, 233 beds, or 8.4%, are allocated from the acute care beds.

The distribution of acute care rated beds and the personal care home bed allocations in Winnipeg in April 1989 was:

LOCATION	ACUTE CARE RATED BEDS		PCH ALLOCATION	%
Concordia Hospital	136		(20)	14.7
Deer Lodge Centre	4		(0)	0
Grace General Hospital	301		(35)	11.6
Health Sciences Centre	881		(63)	7.2
Misericordia General Hospital	375		(50)	13.3
St. Boniface General Hospital	617		(25)	4.5
Seven Oaks General Hospital	216		(20)	9.2
Victoria General Hospital	234		(20)	8.5
Winnipeg Municipal Hospital	0		(0)	0
Total	2,764	(1)	(233)	
Less PCH Allocated	233			
TOTAL SUPPLY	2,531			

Note: (1) Within the 2,764 acute care rated beds, there are 8.4% personal care home allocated beds.

Taking into account the current experiences of Continuing Care, the allocated beds appear to be marginally adequate, perhaps under-utilized, over an extended period, to address the rate (maintaining an overall monthly average of approximately 425 persons awaiting placement) at which people are panelled in the institutions.

However, fluctuations in the admission rate to the personal care home beds and in the numbers of persons awaiting the panelling process cause considerable difficulty and congestion for the institutions on a regular and re-occurring basis with respect to effective and efficient use of their beds for short-term care. There is a concern among the institutions that the congestion of their beds, often beyond their allocations, hampers their ability to provide early rehabilitation and assessment, which would very likely otherwise avoid or minimize the need for institutional bed utilization for persons not requiring panelling.

The Task Force noted that there appears to be an inequitable distribution of the allocated beds among the acute care facilities. Further, there is no system of mechanism to balance the use of these beds and the associated distribution of panelled persons; i.e., one facility could have more panelled persons than the number of beds formally allocated while another could be well below its allocation. It becomes the responsibility of the affected facility and Continuing Care personnel to address the problem, generally through expedited personal care home placement or interim arrangements for service support in the community; otherwise the person remains in the institution.

6. PLACEMENT PROCESS ISSUES - There was a review of the personal care home placement process with Continuing Care personnel to examine a variety of issues, such as:

   a) the patient's ability to choose a personal care home and wait for a vacancy;
   b) the personal care home's ability to refuse a panelled individual;
   c) the sequence of admission - criteria and priority setting;
   d) waiting lists;
   e) waiting time in an acute care setting; and,
   f) the use of the beds allocated for panelled persons.

In its examination of these issues, the Task Force has noted the following:

6.1 The present distribution, acceptance, and use of allocated personal care beds within acute care facilities is accompanied generally with an inappropriate environment (physical accommodation and program supports) for persons awaiting transfer to non-acute beds, particularly over a prolonged period of time; and,

6.2 Although there is an established city-wide system to assess, prioritize, and place panelled persons by Continuing Care, there are substantial variations in waiting time for admission to personal care home due to a number of factors, including:

- the person's sex (where single accommodation is not available),
- level of care requirements in relation to the demands already on the personal care home,
- the individual's choice of home, and
- the availability of beds resulting from the naturally expected demise of the residents.

6.3 In recent years Continuing Care has generally experienced good co-operation with the personal care homes with give and take by both parties to the overall benefit of the system. Less than 10% of admissions to personal care homes are considered to be problematic. Presently there are 30-50 "difficult placements," generally requiring the highest level of care (4) on the list at any given time. The personal care homes are consulted about these placements. Any home's reluctance to accept an individual is thoroughly pursued by Continuing Care and is generally based on the home's resource demands by residents already under its care. In these circumstances, the personal care home advises the patient and family directly to facilitate alternate placement decision making. Given this co-operation and the personal care home's responsibility for the care and safety of their residents, no change in the home's present practices is suggested.

6.4 Concerning the use of acute care and rehabilitation beds, there are real problems associated with the individual's ability to choose a personal care home and refuse alternate placement. An unfortunate result is often a prolonged stay in an inappropriate environment with an unsuitable quality of life relative to that available in personal care home settings. Given the other factors affecting the personal care home placement, there will always be people in acute care settings waiting to be transferred and accordingly the concept of a number of beds being allocated is valid; however, the period of waiting in the acute care or rehabilitation setting should be as short as possible.

6.5 While the average age at admission for people entering personal care homes has been increasing over the years to its current level of 85, there is now the question of whether the advances in physical health (with later use of intensive health services) are starting to be more than offset by mental health problems of the elderly. Increasingly, the acute care and rehabilitation facilities as well as the personal care homes, are finding their existing physical accommodation as well as staffing expertise to be unsuited for appropriate management of these cases. This is becoming as great a challenge to quick and suitable personal care home placement as are physical problems or ailments. The exploding demand for psychogeriatric services and related professional training substantiates this. Whether the average age at admission to personal care homes will, or can be increased despite these mental health issues remains to be seen. As a result, in the resource planning process it is impractical to rely on further reduced or deferred demand for personal care home beds due to a progressively aging population. Further, the real challenge is to address the resource requirements associated with these mental health issues for the elderly.

7. PERSONAL CARE HOME BED SUPPLY IN OTHER PROVINCES - In re-assessing the needs for personal care home beds in Winnipeg and Manitoba following receipt of reactions to the Interim Report, the Task Force was able to confirm that per 1,000 population aged at least 75 years:

- Ontario has in excess of 180 personal care home beds;
- Saskatchewan has 180 personal care home beds; and,
- Alberta has set a goal of reducing its ratio to 150 personal care home beds.

8. BED SUPPLY OPTIONS - Of all the non-acute care beds, the greatest impact of the demographic changes will be on the demand for those in personal care homes since approximately 80% of their occupants are at least 75 years of age. Following a review of the anticipated demographic changes for Winnipeg and other associated factors, the Task Force considered the following principle options regarding the supply of personal care home beds for 1996:

Option No. 1 - Maintain the existing bed ratio of 140 personal care home beds per 1,000 population aged at least 75 years and maintain the current related bed allocations within the acute care and rehabilitation bed settings, and increase the number of personal care home beds to achieve the bed ratio. This would require approximately 1,442 beds.

Option No. 2 - Significantly reduce the allocated beds for panelled patients within acute care and rehabilitation bed settings resulting in a higher bed ratio and the addition of beds considerably in excess of 1,442.

Option No. 3 - Do not change the current bed supply nor the allocated panelled patient beds for either acute care or rehabilitation services but change policies which currently delay some patient transfer and placement. Significantly increase the home care and other related service capabilities. Although there would be no capital expenditure, the bed supply ratio would decrease to approximately 106 per 1,000 population aged at least 75 years, inappropriately low in any comparison.

Option No. 4 - Maintain the panelled patient bed allocations as they currently are for the acute care and rehabilitation services, institute policy changes to minimize transfer delays, significantly increase the home care and other related service capabilities, and build personal care bed facilities to satisfy a 1996 ratio of 135 beds per 1,000 population aged at least 75 years. This would result in approximately 1,232 new personal care home beds.

Option No. 5 - Maintain the panelled patient bed allocation numbers approximately as they currently are for the acute care and rehabilitation services but redistribute on a more equitable basis and to facilitate more effective rehabilitation and assessment services for the elderly, institute policy changes to

minimize transfer delays, significantly increase the home care and other related service capabilities, and build personal care bed facilities to satisfy a 1996 ratio of 140 beds per 1,000 population aged at least 75 years. This would result in approximately 1,442 new personal care home beds.

Option number 5 was selected by the Task Force as the basis for its recommendation on this issue.

RECOMMENDATION 19

IT IS RECOMMENDED THAT PERSONAL CARE HOME BED FACILITIES BE BUILT TO SATISFY A 1996 RATIO OF 140 BEDS PER 1,000 POPULATION AGED AT LEAST 75 YEARS FOR WINNIPEG, RESULTING IN APPROXIMATELY 1,442 ADDITIONAL PERSONAL CARE HOME BEDS TO TODAY'S INVENTORY;

HOWEVER, THE FOLLOWING CONDITIONS MUST BE MET:

A) MAINTAINING THE PERSONAL CARE HOME BED ALLOCATION NUMBERS APPROXIMATELY AS THEY CURRENTLY ARE FOR THE ACUTE CARE AND REHABILITATION SERVICES;

B) INSTITUTING POLICY CHANGES TO MINIMIZE TRANSFER DELAYS TO FACILITATE MORE EFFECTIVE REHABILITATION AND ASSESSMENT SERVICES FOR THE ELDERLY; AND,

C) SIGNIFICANTLY INCREASING THE HOME CARE AND OTHER RELATED SERVICE CAPABILITIES;

AND FURTHER:

1. IT IS CRITICAL THAT THE CONDITIONS ASSOCIATED WITH THE ACHIEVEMENT OF THESE BED SUPPLY VOLUMES BE INSTITUTED, WORKING AND EVALUATED BEFORE ANY CONSIDERATION BE GIVEN TO ATTEMPTING TO REDUCE THE RATIO BELOW 140 PERSONAL CARE HOME BEDS PER 1,000 POPULATION AGED AT LEAST 75 YEARS.

2. SINCE NOT ALL OF THE PERSONAL CARE HOME BEDS WILL COME INTO SERVICE AT THE SAME TIME, IT IS IMPERATIVE TO MONITOR THE WAITING LIST AND TO ENSURE THAT THE PROPOSED RATIO IS STILL NECESSARY TO ADDRESS THE NEED.

3. CURRENT PRESSURES FOR PERSONAL CARE HOME BEDS FROM ACUTE CARE AND COMMUNITY SETTINGS ARE EXPECTED TO ESCALATE IN THE SHORT TERM FUTURE. THESE PRESSURES CAN BE RELATED TO THE DROP IN THE RATIO OF PERSONAL CARE HOME BEDS PER 1000 POPULATION AGED AT LEAST 75

YEARS, FROM 165 IN 1981/82 TO 147 IN 1987/88, TO 140 CURRENTLY. DURING THE PLANNING AND CONSTRUCTION PHASES THE RATIO WILL BE FURTHER REDUCED. HOSPITALS, REHABILITATION UNITS, COMMUNITY SERVICES, PATIENTS, FAMILIES, THE PUBLIC, AND GOVERNMENT WILL HAVE TO ADJUST THEIR EXPECTATION OF HEALTH SERVICES ACCORDINGLY.

RECOMMENDATION 20

IT IS RECOMMENDED THAT ADDITIONAL MANPOWER AND FUNDS BE MADE AVAILABLE IN CONJUNCTION WITH THE INCREASED DEMANDS FOR PANELLING ANTICIPATED FOR THE INCREASE IN PERSONAL CARE HOME BEDS AND ASSOCIATED OPERATIONAL NEEDS CONCERNING ASSESSMENTS, NUMBER OF PANELS, AND PLACEMENTS.

Rationale:

1. It is imperative that the necessary administrative support be provided to assure expedient and optimal utilization of the personal care home beds as well as the associated acute care and rehabilitation beds.

RECOMMENDATION 21

IT IS RECOMMENDED THAT THE ADDED PERSONAL CARE HOME BEDS SHOULD BE APPROXIMATELY 44% (635 BEDS) NON-SECULAR, CONSISTENT WITH THE CURRENT SUPPLY RATIO.

Discussion and Rationale:

1. The earlier version of this Task Force recommendation was of concern as evidenced in the responses to the Interim Report.

   The Task Force acknowledges the invaluable leadership, dedication, and contribution of the many religious and cultural organizations that have assumed responsibility for many of Manitoba's health care institutions and related service agencies. Through their services the quality of life of thousands has been enhanced. The associated volunteer efforts are also an essential ingredient for the successes and challenges of our health systems.

   Respondents to this section of the Interim Report supported the theme contained in a portion of the message conveyed by Mr. G. Remillard, Chairman of the Board of Tache Nursing Centre, as follows:

"No reasonable person would expect that all the needs of all the people will ever be fully met, however, the system should allow for as many needs as possible to be met. There is no reason why a Personal Care Home could not decide to provide programs and services to a small target group if there is sufficient demand without dedicating the total facility to that group and letting it be known to the community that it is providing these programs and services. This group could consist of only five or six people sharing a common background, have similar interest, etc. Just living together can increase their quality of life even if there aren't any special programs or services."

It is this very spirit of determined and sensitive volunteerism on behalf of our citizens and community that must be heeded and preserved.

2. It is important to note that individuals WILL CONTINUE TO HAVE CHOICE OF PERSONAL CARE HOME.

   Again, in reference to the respondents to the Interim Report, the Task Force completely agreed with the view that "The personal care homes become the private residence of the patients and they must feel comfortable in these settings. It is important to maintain family relationships and the location may be important to some families." - T.I. Bartman, Executive Director, Misericordia General Hospital.

3. With increasing numbers of the various cultural and religious components of Canada's and Winnipeg's citizens, it is highly unlikely that enough personal care homes dedicated to specific ethnic or religious groups could ever be built and operate within the current and projected economic constraints. Having a supply of secular beds would help to address these pressures.

RECOMMENDATION 22

IT IS RECOMMENDED THAT THE ADDED PERSONAL CARE HOME BEDS AND ASSOCIATED PROGRAMMING, AS WELL AS ANY BEING REPLACED, SHOULD BE PREDOMINANTLY FOR HEAVY CARE (LEVELS 3 & 4) AND INCLUDING THE COGNITIVELY IMPAIRED ELDERLY, SOME OF WHOM REQUIRE LEVEL 2 CARE. IN GEOGRAPHIC AREAS IN WHICH THERE ARE ONLY MULTI-LEVEL (I.E., 2, 3 AND 4) PERSONAL CARE HOMES, CONSIDERATION SHOULD BE GIVEN TO HAVING AT LEAST ONE FACILITY FOR HEAVY CARE.

Discussion and Rationale:

1. Current experiences concerning personal care home panelling processes indicate that there is about a 2/3 requirement for levels 3 and 4 care and the remainder for level 2.

2. There are difficulties currently in placing persons requiring levels 3 and 4 care in geographic areas where there are primarily multi-level personal care homes.

RECOMMENDATION 23

IT IS RECOMMENDED THAT PERSONAL CARE HOMES PROVIDE TRAINING AND EDUCATIONAL OPPORTUNITIES FOR STAFF IN THE MANAGEMENT OF THE COGNITIVELY IMPAIRED TO ENSURE APPROPRIATE CARE AND TO REDUCE WORK-RELATED STRESS.

RECOMMENDATION 24

IT IS RECOMMENDED THAT PERSONAL CARE HOMES ADAPT THEIR TRADITIONAL STAFFING MIX, TYPES OF STAFF, STAFFING PATTERNS, PHYSICAL ENVIRONMENT AND UNIT ORGANIZATION TO MEET THE NEEDS OF THOSE RESIDENTS WHO ARE MOST SEVERELY DYSFUNCTIONAL BECAUSE OF BEHAVIOURS RELATED TO A PSYCHOGERIATRIC CONDITION.

Discussion and Rationale for Recommendation 23 and 24

1. The Task Force raises these issues because of their importance to the effective utilization of beds.

2. The average age of admission to a personal care home is now 85 years. Approximately 30% of personal care home residents have been diagnosed with psychiatric or mental conditions. The prevalence rate of dementia among elderly aged 85 and over is 20 - 25%. The average age of residents at admission has been increasing and the likelihood of personal care home residents having alzheimer and related dementias is significantly higher. Whereas the majority of personal care home residents do not present a care management problem, an estimated 7 to 10% of all personal care home residents have severe behavioural dysfunctioning which demands modification to both care management and the physical environment. Traditional routines and unit activities exacerbate the troublesome behaviours and cause problems for the individual, staff and the other residents.

3. Staff in all personal care homes will be involved to some extent in meeting the special needs of psychogeriatric residents; therefore, all should receive special training. Professional staff with experience and/or additional education in psychogeriatrics are required. This would include registered nurses, registered psychiatry nurses, licensed practical nurses, social workers, recreational therapists and occupational therapists. Educational opportunities should be developed in areas where they do not now exist or are limited.

RECOMMENDATION 25

IT IS RECOMMENDED THAT THE DISTRIBUTION OF THE ADDITIONAL PERSONAL CARE HOME BEDS IN WINNIPEG BE AS FOLLOWS:

DISTRICT/AREA	NUMBER OF BEDS
Fort Rouge, River Heights, East Tuxedo	360
Elmwood, East Kildonan, North Kildonan, East St. Paul	360
West End area bounded by Sherbrook St., Portage Avenue, Route 90 and Assiniboine River	360
Undesignated to address specific needs in smaller geographic areas identified by the Manitoba Health Services Commission	362
Total	1,442

Rationale:

1. The three areas specifically designated were identified previously by Manitoba Health Services Commission personnel as being significantly deficient in personal care home bed supply, based on a bed per 1,000 population aged at least 70 years ratio of 90, the population as of December 1, 1987, and the changes in the bed count effected by the proposed 1988/89 capital program.

2. The provision of 360 personal care home beds in each of the three designated areas should address not only local needs but also the related concerns of the acute care and rehabilitation service sectors, for example those of Concordia Hospital.

3. The recommendation allows for the distribution of 362 personal care home beds in parts of Winnipeg according to emerging needs between now and 1996, taking into account those areas that were considered to have a surplus of beds in relation to the criteria identified in rationale 1, as well as demographic changes within the areas.

RECOMMENDATION 26

IT IS RECOMMENDED THAT THE HIGHEST PRIORITY FOR PERSONAL CARE HOME CONSTRUCTION BE GIVEN TO THE EAST KILDONAN - ELMWOOD - NORTH KILDONAN - EAST ST. PAUL AREA.

Rationale:

1. This would help to address the substantial pressures for personal care home placements being experienced by Concordia Hospital as further reinforced by its disproportionate number of personal care home allocated beds (14.7%) in relation to other acute care facilities. This would also relate to the rationale for recommendations 27 and 28, as well as the earlier discussion in sub-section 5 - Allocated Beds, of this section dealing with personal care home beds.

2. An increased personal care home bed supply in the immediate area should alleviate some of the related pressures on the acute care beds at Concordia Hospital.

RECOMMENDATION 27

IT IS RECOMMENDED THAT UP TO 230 PERSONAL CARE HOME BEDS OF THE 360 FOR THE FORT ROUGE - RIVER HEIGHTS - EAST TUXEDO AREA BE LOCATED AT THE SITE OF THE WINNIPEG MUNICIPAL HOSPITAL.

Discussion and Rationale:

1. In addition to its expansive and scenic property which could readily accommodate a variety of buildings and non-acute bed services in a complementary relationship, Winnipeg Municipal Hospital has acquired a new power plant facility in 1988 at a cost $3,776,400. The plant serves the existing 337 bed and supporting facilities, and with some additional cost, but working within the original design features, capacity can be upgraded to serve 409 beds.

2. Any concerns about the total bed complement and associated organizational size for the site should be able to be addressed through innovative architectural and administrative designs as well as corporate sponsorship.

3. The needs of the adult disabled (also referred to as the young disabled) are discussed elsewhere in this report. Consideration should be given to addressing their needs in relation to the development of Winnipeg Municipal Hospital.

4. There are 54 personal care home allocated beds at the Winnipeg Municipal Hospital which would require replacement in conjunction with changes to the facilities at the site.

5. Some of the 360 personal care home beds needed for the area could be added to complement the services proposed for the Winnipeg Municipal Hospital elsewhere in this report.

RECOMMENDATION 28

IT IS RECOMMENDED THAT THE NUMBER OF PERSONAL CARE HOME ALLOCATED BEDS BE REDUCED FOR CONCORDIA HOSPITAL FOLLOWING THE CONSTRUCTION OF THE NEW PERSONAL CARE HOME BEDS IN ITS AREA.

Rationale:

1. This should further reduce the acute care bed pressures for that hospital.

2. The personal care home allocated beds at Concordia Hospital should be relatively rationalized similarly to those at other acute care hospitals once circumstances permit.

Recommendations Concerning Personal Care Home Beds Pertinent to the Acute Sector

RECOMMENDATION 29

IT IS RECOMMENDED THAT THERE BE NO CHANGE IN THE TOTAL NUMBER OF PERSONAL CARE HOME BEDS ALLOCATED TO THE ACUTE HOSPITAL BEDS.

Rationale:

1. Even if the 233 Personal Care Home allocated beds are subtracted from the total number of acute beds in Winnipeg, an acceptable ratio of beds per 1,000 population by Canadian standards for urban hospitals remains.

2. The 233 beds constitute 8.8% of all acute beds (although in April, 1989, when a census was taken only 6.7% of acute beds were used). In contrasts, Quebec's future goals (Orientations 1989) include the objective to reduce their hospitals' percentage from 15% to 12%, and Marshall's study [models for community-based long-term care (1989)] indicates that just over 12% of acute beds in Ontario's cities are occupied by persons in transit to long-term care facilities.

3. Winnipeg is currently operating at 140 personal care home beds per 1,000 elderly aged at least 75 years, a drop from 165 in 1981/82 (M.H.S.C. Annual Reports). With this ratio due to continue to fall over the next few years until new personal care home beds are ready for occupancy it is anticipated it will become increasingly difficult to maintain this relatively low percentage of hospitalized persons awaiting placement.

RECOMMENDATION 30

IT IS RECOMMENDED THAT THE MANITOBA HEALTH SERVICES COMMISSION AND THE OFFICE OF CONTINUING CARE REVIEW THE DISTRIBUTION OF PERSONAL CARE HOME ALLOCATED BEDS IN ALL WINNIPEG ACUTE HOSPITALS TO MAKE THE DISTRIBUTION OF THESE BEDS AS EQUITABLE AS POSSIBLE.

Rationale:

1. The Committee noted that the percentage of Personal Care Home allocated beds to total acute beds differed from hospital to hospital. The Committee recognized that the apparent inequities may be unavoidable because of the specific location and clientele of each hospital but felt a review is needed to change or justify existing differences.

RECOMMENDATION 31

IT IS RECOMMENDED:

(a) THAT THE PERSONAL CARE HOME CHOICE OF THE HOSPITALIZED APPLICANT BE HONORED BUT THAT THE LONGEST WAITING APPLICANTS BE THE FIRST TO BE REQUIRED TO ACCEPT AN INTERIM PLACEMENT (ADDRESSING THE INDIVIDUAL'S SPIRITUAL AND CULTURAL NEEDS WHERE POSSIBLE) IN ANY PERSONAL CARE HOME BED OR REHABILITATION UNIT BED IF THE HOSPITAL HAS THE MAXIMUM NUMBER OF PANELLED PERSONS IN ITS PERSONAL CARE HOME ALLOCATED BEDS BUT IS NOT AT THEIR MAXIMUM OF PERSONAL CARE HOME ALLOCATED BEDS IN THE REHABILITATION UNIT;
HOWEVER, THE INDIVIDUAL TRANSFERRED TO AN INTERIM PERSONAL CARE HOME BED WOULD RETAIN THEIR POSITION ON THE WAITING LIST FOR THE PERSONAL CARE HOME OF THEIR CHOICE UNLESS THEY WITHDREW;

(b) THAT CONTINUING CARE ADOPT A POLICY OF MAKING EVERY ATTEMPT TO PLACE THE LONGEST WAITING PERSONAL CARE HOME PANELLED PATIENTS BEFORE THOSE WAITING LESS TIME, EVEN IF THIS INVOLVES AN INTERIM PLACEMENT; AND,

(c) THAT TO FACILITATE THIS POLICY CHANGE, A PUBLIC EDUCATION PROGRAM FOR THE PROVINCE, AGENCIES AND THE HOSPITALS BE DEVELOPED TO EXPLAIN THE NEED AND RATIONALE FOR INTERIM PLACEMENT TO PATIENTS AND FAMILIES;

CONTINGENT UPON:

(a) THE ADDITION OF THE REQUIRED NUMBER OF PERSONAL CARE HOME BEDS TO REATTAIN THE RATIO OF 140 BEDS PER 1,000 POPULATION AGED AT LEAST 75 YEARS BY 1992;

(b) AS THEY ARE BROUGHT INTO SERVICE, 20% OF THE NEW BEDS BEING ADDED UNTIL 1996 ARE TO BE SET ASIDE ON A ROTATIONAL BASIS FOR THE EXCLUSIVE USE OF CONTINUING CARE TO PERMIT IT TO MAKE INTERIM PLACEMENTS;

(c) PERSONAL CARE HOMES BEING ENCOURAGED TO ACCOMMODATE INTERIM PLACEMENTS; AND,

(d) THE ADDITION OF THE REQUIRED MANPOWER AND FUNDING TO CONTINUING CARE TO ADDRESS THE RELATED PRESSURES AND NEEDS AS THEY ARISE.

Discussion and Rationale:

1. Although the current system ensures that placement from hospitals gets priority if they are reaching or have reached their maximum capacity within personal care home allocated beds, the person waiting longest is not necessarily the first accommodated because that person may have chosen a personal care home which has a long waiting list or a low absorption rate.

   Since acute service areas of hospitals are neither equipped to deal appropriately with the very long-stay patient, nor is such a hospital stay in the best interest of the individual, every effort should be made to have persons transferred to a long-stay facility.

2. Within the contingency statements, the reference to the 20% of new beds being seconded to Continuing Care is intended to facilitate the interim placement processes. The building of the proposed personal care homes would be staggered and in conjunction with their opening, 20% of each home's beds would be designated for interim placement on a temporary basis. When a bed becomes available in the personal care home of the resident's original choice (s)he would be transferred there, freeing the interim bed for a regular personal care home admission, unless (s)he chooses to remain.

ADULT DISABLED

Before presenting the recommendations of the Task Force on Extended Treatment Bed Review concerning the Adult Disabled, it is important to acknowledge the substantial work that has been done over the years in studying and addressing the needs of this group of people in Manitoba. In 1982 the Manitoba Council on Aging issued a report on the Young Disabled in personal care homes wherein it was stated that they should have separate facilities from the elderly in personal care homes. Almost a year later, in January, 1984, the Task Force on the Young Disabled provided several recommendations to guide the development and provision of services.

There are a number of organizations, projects, and agencies working together on behalf of the adult disabled, such as the Canadian Paraplegic Association, Ten Ten Sinclair Housing Inc., FOKUS Housing, Luther Home, Foyer Valade, Tache Nursing Centre, Winnipeg Municipal Hospital, the HIDI project, and the Committee on Manitobans with Special Needs.

The Task Force on the Young Disabled determined that it was appropriate to refer to this group as the "Adult Disabled" since it includes the ages 18 to 59 years. That Task Force determined that for the associated diagnostic categories over the age of 59, most often the individuals were appropriately placed in personal care homes since their needs were similar to those residents aged 65 years or more.

In the report a disabled person was described as "one whose handicaps in daily living are chronic (stable or unstable). These handicaps may result from a condition of birth or from accident or disease at any age, and are not generally associated with the normal aging process."

Among the recommendations of the Task Force on the Young Disabled, the following were considered to be pertinent to the deliberations of the Task Force on Extended Treatment Bed Review:

> "2. (page 15). Given that some disabled persons in personal care homes, for a variety of reasons, consider these facilities to be there 'homes' and feel most comfortable and secure in such care environments, government should support:"
>
> > "(a) Development of personal care home programs which would better accommodate and be more responsive to the lifestyle of the younger resident."

"(b) Development of the alternatives separate from existing facilities. This separation could take the form of a wing or module related to an existing facility or a small scale, free-standing home where the physical design and staffing are planned primarily for the younger disabled person."

"3. (page 15).

(a) That funding be allocated for establishing and implementing group living and quasi-institutional facilities."

"(b) That priority be given to establish a quasi-institutional facility in Winnipeg....."

"4. (page 15).

(a) That consideration be given to providing for 'habilitation suite(s)', where residents may visit with spouses and/or families, within facilities developed for younger disabled persons."

"6. (page 16).

(a) That Ten Ten Sinclair be viewed as a valuable provincial resource for those disabled persons that require the particular services offered by this facility."

"(b) That one facility offering resources at this point on the continuum is adequate to meet the needs of the adult disabled population in Manitoba."

"7. (page 16).

That the concept of 'transitional living', where disabled residents are offered opportunities to develop self management skills in preparation for more independent community living, be supported and encouraged in any type of setting."

"13. (page 18).

(a) That whenever feasible, provision be made for respite capacity within special group living facilities."

"(b) That additional respite programs be supported to provide adequate respite resources throughout the Province."

In reviewing current practices pertaining to these recommendations with Manitoba Health Services Commission personnel and Dr. S. MacDonald, former Chairperson of the Committee on Manitobans with Special Needs, the Task Force learned that:

(a) care in the home is being increasingly provided for disabled persons beyond that contemplated in the recent past; i.e., more people with greater degrees of handicap are being cared for in the community as a result of changing treatment and care regimes.

(b) there has been an increasing emphasis to provide community living with support for the adult disabled.

(c) there has been an attempt to group the adult disabled and provide supportive programs within certain personal care homes, specifically Luther Home, Foyer Valade, Tache Nursing Centre, and the Beacon Hill. Of 147 residents less than 60 years of age in the Winnipeg personal care homes, as of April 1, 1989, there were 92 in the four facilities mentioned, with the rest dispersed among other homes.

(d) age alone cannot be used as a criterion for grouping persons in a care setting; diagnosis, responsiveness, cognitive impairment, program requirements, expertise requirements and locale of family (or significant other) residence are important additional determinants.

(e) the use of personal care home beds by the adult disabled is expected to affect the supply of those beds since they are expected to be occupied for substantially longer periods of time than those occupied by the elderly residents with their current average length of stay of four years.

(f) as of October 27, 1989, there will be 14 persons with an age less than 61 years awaiting placement in a personal care home.

(g) there is a consensus among the caregivers in the institutions that the placement of younger adults among the elderly and the provision of care generally has not been a positive experience for the patients, staff, and the families. The young adults tend to have more service needs than the elderly and the family expectations are generally greater.

RECOMMENDATION 32

IT IS RECOMMENDED THAT IN THE DEVELOPMENT OF THE PLANS TO INCREASE THE NUMBER OF PERSONAL CARE HOME BEDS IN WINNIPEG, PROVISION BE MADE TO GROUP YOUNG DISABLED ADULTS IN APPROPRIATE SETTINGS WHERE IT WOULD BE CONSIDERED TO BE BENEFICIAL TO THEIR CARE AND LIFESTYLE, AND THAT IN CONJUNCTION WITH THIS, TRANSFERS OF YOUNG ADULTS BE FACILITATED INTO THESE SETTINGS ONCE AVAILABLE.

Transitional Facility Needs of Brain Damaged Persons

Also in conjunction with these deliberations, the Task Force considered Dr. N. Hill's draft report of August 30, 1989 requesting the establishment of a transitional facility to assist brain damaged persons in their return to the community. Given recommendation 6 (a) and 6 (b) [page 16] of the Task Force on the Young Disabled and the uncertainty of the Task Force on Extended Treatment Bed Review concerning utilization of the Ten Ten Sinclair facility, it could not be determined whether it would be appropriate to place brain damaged persons there for their community skills development. In addition, the 1988 Annual Report of Ten Ten Sinclair Housing Inc. indicates that funding is not being provided to address increasing program needs associated with more demands for tenancy from persons requiring high amounts of personal care.

This is a critical issue to be addressed if the facility is to accommodate brain damaged persons because additional resources would be required to assist these persons with learning life skills. A recommendation proposing a new transitional facility for brain damaged persons could not be supported pending resolution of all the foregoing issues.

RECOMMENDATION 33

IT IS RECOMMENDED THAT THE USE OF TEN TEN SINCLAIR TO PROVIDE THE TRANSITIONAL FACILITY NEEDS OF BRAIN DAMAGED PERSONS BE CONSIDERED BEFORE CONSIDERING ANY PROPOSAL TO BUILD AND OPERATE ANY ASSOCIATED NEW UNIT.

Independent Living Needs of Disabled Adults

FOKUS Housing is administered by Ten Ten Sinclair Housing Inc. It enables more severely disabled adults to live out of personal care homes, be more productive, and build a lifestyle tailored to their individual needs and abilities. There are currently four units accommodating a total of 44 persons. The primary prerequisites for the candidates for these units are that the tenant must be capable of making decisions, taking full responsibility for organizing his/her own needs and activities, and require personal care services on a daily basis.

The 1988 Annual Report of Ten Ten Sinclair Housing Inc. indicates that the organization has been exploring the development of alternative housing models, requiring shorter establishment times than the FOKUS units, presumably to be more responsive to service demands.

RECOMMENDATION 34

IT IS RECOMMENDED THAT ENCOURAGEMENT AND FUNDS BE PROVIDED FOR THE CONTINUED DEVELOPMENT OF FACILITIES AND PROGRAMS SIMILAR TO THOSE OF FOKUS UNITS ADMINISTERED BY TEN TEN SINCLAIR HOUSING INC. AS THE NEED ARISES.

ADULT DAY CARE

Manitoba currently has 52 Day Care Programs, providing 56,568 spaces throughout the province. The programs are administered by the Manitoba Health Services Commission. Admission is based on assessments conducted by Continuing Care.

A day care space is a budgetary unit providing day care programming for a person the equivalent of one day per week. Through scheduling, more individuals may be associated with a given number of day care spaces than the number would at first glance suggest; for example, 20 people could benefit from 10 day care spaces through attendances on alternate days.

The purpose of the Adult Day Care Program is to:

a) provide socialization and recreational activities in a supportive environment to those most at risk of institutionalization,

b) offer social relief to caregivers (many of whom are elderly spouses which provide most of the care), and

c) maximize independent functioning so the individuals can continue to remain at home.

The growth in the number of old elderly and the lower institutional rate associated with the gradual reduction in the ratio of personal care home beds per 1,000 population aged at least 75 years has increased the need for adult day care spaces.

RECOMMENDATION 35

IT IS RECOMMENDED THAT THE NUMBER OF DAY CARE PROGRAM SPACES BE INCREASED TO SUPPORT THE AVOIDANCE AND DEFERRAL OF INSTITUTIONALIZATION OF THE ELDERLY FOR AS LONG AS APPROPRIATELY POSSIBLE.

Discussion and Rational:

1. The Task Force was advised that a budgetary submission has been prepared by personnel from the Manitoba Health Services Commission and the Office of Continuing Care to address Day Care Program space needs and is under review at senior levels. The submission was not available for study by the Task Force. Since it is presumed that the submission contains appropriate needs definition and resource allocation requests, the Task Force encourages the approval of the associated resource supports and program expansion.

CONTINUING CARE PROGRAM

In its deliberations pertinent to the preceding sections of this Report, the Task Force noted the intimate relationship of the Continuing Care program to both the acute and non-acute bed sectors and the expanded role it is being called upon to ensure optimal utilization of a limited bed supply.

Therefore, the Task Force Committee provides the following recommendations concerning the Continuing Care program.

RECOMMENDATION 36

IT IS RECOMMENDED THAT THE CONTINUING CARE PROGRAM BE FUNDED ON AN ADEQUATE BASIS TO ENSURE THAT IT CAN FULFILL THE EXPANDED FUNCTIONS AS DETAILED IN THIS REPORT IN ADDITION TO ITS CURRENT RESPONSIBILITIES.

RECOMMENDATION 37

IT IS RECOMMENDED THAT ADDITIONAL FUNDS BE ALLOCATED TO THE CONTINUING CARE PROGRAM BEYOND THOSE OUTLINED IN RECOMMENDATION 36 TO ENABLE THE PROGRAM TO FUNCTION ON A 7 DAY-A-WEEK, 24 HOUR DAY BASIS IN ORDER TO ENSURE THAT THE MAXIMUM NUMBER OF HOSPITAL DISCHARGES AND PERSONS AWAITING PLACEMENT IN ACUTE BEDS, REHABILITATION BEDS AND IN THE COMMUNITY CAN BE CARED FOR AT HOME.

Rationale:

1. The rapidly falling PCH bed/population ratio in the face of increasing numbers of older elderly while no new beds are available will, as has already been indicated, place great pressure on the acute and non-acute bed sectors as well as on individuals and their families. Some of this pressure could be relieved if additional resources were made available to Continuing Care specifically to provide help to persons assessed as requiring it on a 7 day-a-week and a 24 hour-a-day basis.

2. The implementation of this recommendation would permit the Continuing Care Program to develop the capacity and the flexibility to respond to situations such as occassional overcrowding in a hospital emergency unit, periodic occupancy of acute and rehabilitation beds beyond the PCH-allocated maximum in a specific hospital, and persons requiring palliative care at home.

3. It would also permit Continuing Care to respond immediately to a temporary "breakdown" in the care and support of a home care recipient. The result of an inability or a delay in responding to such a breakdown (whether due to the sudden illness of a key caregiver or the sudden deterioration of the care recipient) can prejudice the safety of individuals and increase the demand by relatives for an immediate placement in a personal care home.

4. Whereas for many years most hospital discharges were made 9:00 to 5:00 Monday to Friday, they are increasingly moving towards a 7-day-a-week discharge policy and towards earlier discharge to maximize efficient utilization of beds. This requires that Continuing Care be able to respond appropriately in accepting discharge caring for persons less advanced in the recovery process than formerly.

- end -

APPENDIX A

ORGANIZATIONS AND INDIVIDUALS
RESPONDING tO tHE INTERIM REPORT
(in order of receipt)

	Agency/Organization	Name of Respondent
1.	Community Therapy Services Inc.	I. Corobow
2.	Calvary Temple	Ron. H. H. Barber
3.	Provincial Gerontologist	B. Havens
4.	Rheumatology/Health Sciences Centre	Dr. F. Baragar
5.	Deer Lodge Centre	R. S. Brown
6.	Seven Oaks General Hospital	Dr. F. D. Pauls
7.	Salvation Army Grace General Hospital	Major E. Taylor
8.	St. Boniface General Hospital	L. A. Quaglia
9.	Concordia Hospital	H. Willms
10.	Victoria General Hospital	G. Fletcher
11.	Misericordia General Hospital	T. I. Bartman
12.	Winnipeg Municipal Hospital	N. R. Kasian
13.	The Sharon Home Inc.	G. M. Pullan
14.	Holy Family Nursing Home	N. W. Diakiw
15.	The Middlechurch Home of Winnipeg	N. Kaisaris
16.	Meadowood Manor	G. Chernoff
17.	The Sharon Home Inc.	Dr. H. Faintuch
18.	Arcadia Nursing Home Ltd.	M. Baron
19.	West Park Manor Personal Care Home Inc.	E. A. Gallant
20.	St. Joseph's Residence Incorporated Pura	Sister Gerda S.K.

21.	Mennonite Brethren Geriatric Association	H. Klassen
22.	Park Manor Personal Care Home Inc.	C. L. Toop
23.	Bethania Mennonite Personal Care Home	J. Loepp
24.	Fred Douglas Lodge	R. G. Beaudin
25.	Fort Garry Care Centre	M. C. King
26.	Golden Links Lodge	H. H. Nikkel
27.	Tache Nursing Centre	G. Remillard
28.	Provincial Task Force on Health Services for the Elderly	N. R. Chappell
29.	Manitoba Council for Multicultural Health Inc.	Dr. J. N. H. Du
30.	Heads of Geriatric Services	Dr. P.R. Montgomery Dr. A. J. Kirshen
31.	Continuing Care, Winnipeg North Region	J. Bickford
32.	Society for Manitobans With Disabilities Inc.	D. L. Steen
33.	Catholic Health Association of Manitoba	I. Pepin
34.	Consumer	E. Stevenson
35.	Continuing Care	O. A. Zabloski
36.	Health Sciences Centre	A. R. Thorfinnson
37.	Maternal & Child Health Directorate	S. Hicks
38.	Manitoba Health Organizations Inc.	H. Wilkie
39.	Orthopedic Surgery Rehabilitation Hospital Health Sciences Centre	Dr. D. Lyttle
40.	Meadowood Manor/Manitoba Baptist Home Society	C. Kunze